

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 2 2 9 9 9

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAURA IRENE BAILE			2a. DATE OF DEATH MONTH DAY YEAR 08/05/86		2b. HOUR 0700M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 04/02/01	6. AGE (IN YEARS LAST BIRTHDAY) 85	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.		
10. CITY OR TOWN OF DEATH NEW WINDSOR	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE, ADDRESS, CITY, STATE, ZIP CODE) 1705 OLD NEW WINDSOR RD.		12a. USUAL OCCUPATION (TYPE, ADDRESS, CITY, STATE, ZIP CODE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. MD 13b. CARROLL 13c. NEW WINDSOR 13d. HOME CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ROOM NO. 1705 OLD NEW WINDSOR RD 21776		
14. FATHER'S NAME WILLIAM NEWTON STITELY LAST			15. MOTHER'S MAIDEN NAME EMILY JANE WAGNER LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NONE	16b. SOCIAL SECURITY NO. (IF YES, NONE OR DATES) 218-24-2010	17. INFORMANT ADDRESS DOLLY F. LEESE 2116 BETHEL RD. FINKSBURG, MD 21048			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hyperthyroid heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>multinodular Thyrotoxicosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension; atrial fibrillation</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>1-23</u> , 19 <u>74</u> to <u>7-21</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8-4</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ephraim Barzaga			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-5-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EPHRAIM BARZAGA			22e. ADDRESS NEW WINDSOR, MD 21776		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 08/08/86	23c. NAME OF CEMETERY OR CREMATORY WINTERS CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE NR. NEW WINDSOR CARROLL MD	
24. FUNERAL DIRECTOR'S NAME D. HARTZLER			NEW WINDSOR, MD		25a. DATE REC'D. BY REGISTRAR AUG 7 1986
			25b. REGISTRAR'S SIGNATURE John Davidson-Randall		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes" it shows any injury, or other traumatic event; the medical examiner must be notified prior to burial.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page and return it to the State Department of Health and Mental Hygiene. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal of the body. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other condition, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 6 2 3 0 0 0									
1- FOR STATE REGISTRAR										REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
WALTER DAVID BARNHART										AUG 6		1986		5A		M			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.				
MALE			WHITE			MAY 4 1912			74 YRS			MONTHS			DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
MARYLAND			UNITED STATES						CARROLL MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR						
WESTMINSTER			312 KLINGER DRIVE							Carpenter			Rosewood State Hosp.						
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			
MARYLAND										CARROLL		WESTMINSTER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		312 KLINGER DRIVE 21157			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME														
John Barnhart					Daisy Catherine Barnes														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)					17. INFORMANT					ADDRESS				
Yes					WWII Army					Margaret E. Barnhart					312 Klinger Dr. Westminster, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) CARCINOMA OF PANCREAS										9 MONTHS									
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)									
DUE TO, OR AS A CONSEQUENCE OF										(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
					P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION									
										CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from AUG 57 to AUG 86, that (we) last saw the deceased alive on AUG 6 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										DEGREE					22c. DATE SIGNED				
Daniel I. Welliver										M.D.					8-6-86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
DANIEL I. WELLIVER MD.										218 WASHINGTON HEIGHTS WESTMINSTER MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
Burial					8-8-86					Evergreen Mem. Gardens					CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR					25. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE				
Thomas D. Fletcher & Son F.H.					25a. 8 1986										Julia Davidson-Randall				
254 East Main Street Westminister, Md. 21157																			

WHITE DAVID EXHIBIT AUG 8 1986
 WHITE MAY 4 1985
 WESTWARD UNITED STATES
 WESTMINSTER 312 HUNTER DRIVE
 WESTMINSTER 312 HUNTER DRIVE

CARCINOMA OF PANCREAS 9 HOURS



DANIEL I. WELLS MD
 DANIEL I. WELLS MD
 312 HUNTER DRIVE
 WESTMINSTER 312 HUNTER DRIVE
 AUG 1 1986

00-15520

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 2 3 0 0 1

1. DECEASED NAME (TYPE OR PRINT) BECKER CARL BECKER			2a. DATE OF DEATH MONTH DAY YEAR 8 14 86			2b. HOUR 1235 M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 19 12		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY, MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSPITAL INC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARTENDER.		12b. KIND OF BUSINESS OR INDUSTRY BAR	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. CITY OR TOWN 21204		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1658 YAKONA RD. 21204	
14. FATHER'S NAME FIRST MIDDLE LAST PAUL J. BECKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELENA RAUSCH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR ARMED) W.W. 11 218-03-7196		17. INFORMANT ADDRESS HENRY F. BECKER 8628 OAKLEIGH RD. 21234					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE - CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) "		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

ABDOMINAL AORTIC ANEURYSM INVOLVING RENAL ARTERIES

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/11 , 19 86 , to 8/14 , 19 86 , that (I) (we) last saw the deceased alive on 8/14 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William E. Johnson				DEGREE MD		22c. DATE SIGNED 8/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			

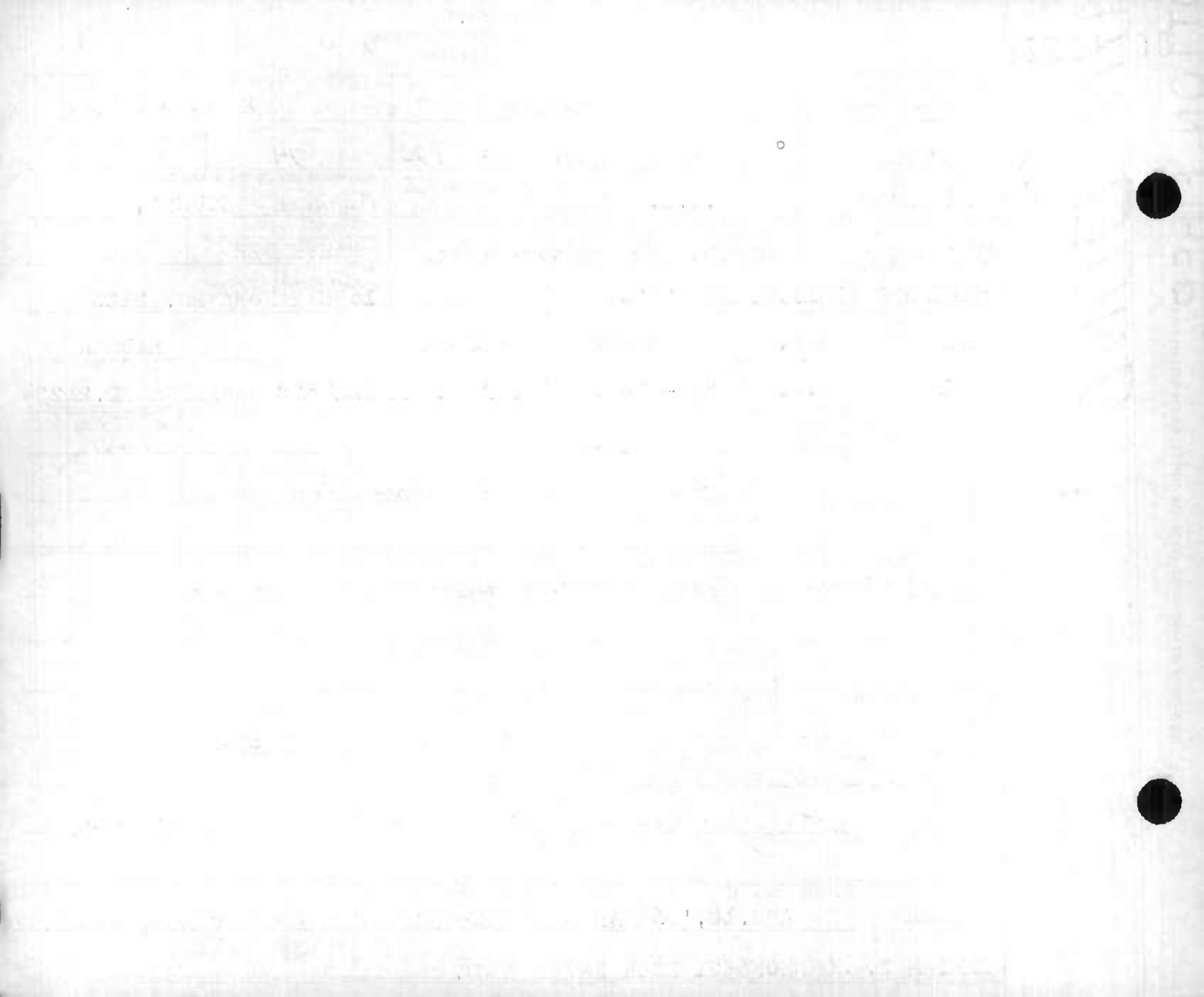
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE AUG. 18, '86		23c. NAME OF CEMETERY OR CREMATORY MARYLAND VETERANS		23d. LOCATION CITY OR TOWN COUNTY STATE GARRISON FOREST, MARYLAND	
24. FUNERAL DIRECTOR NAME WILLIAM E. JOHNSON				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 15 1986			
ADDRESS 8521 LOCH RAVEN BLVD.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. These please remove carbon papers. Pages head 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

23002
REG. NO.

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		7a. DATE KNOWN OF DEATH				7b. HOUR			
Edward James Bewley								<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR				1630 M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				7d. HOUR	
Male	White	11 10 08		77 YRS.						08 31 1986				2030 M	
7e. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7f. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD		USA		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		Carroll County MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Finksburg		3803 Niner Road				Carpenter				A + P					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD		Carroll		Finksburg 21048		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3803 Niner Road 21048							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Michael Bewley				Emma Katherine Snyder											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT							
Yes				NK				Brenda K. Bewley							
				219-03-3499				3803 Niner Rd Finksburg, MD 21048							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:												5 yrs			
IMMEDIATE CAUSE (a) ASCVD															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:															
(b) DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I															
None															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED							
				HOUR A.M. MONTH DAY YEAR				ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET, FACTORY, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE							
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Alva S. Baker MD				M.D. Asst Deputy				8-31-86							
EXAMINER'S NAME				ADDRESS											
(TYPE OR PRINT) Alva S. Baker				330 140 Village Road Westminister MD 21157											
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
BURIAL				September 3, 1986				Good Shephard Cemetery				Ellicott City MD			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Loring Byers Funeral Directors, INC				SEP 2 - 1986				Julia Davidson							
NAME 8728 Liberty Road Randallstown, MD 21133-4784															

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP
DHMH - 17
(VR A15 ME (5))

00-1122

100-1122



100-1122

100-1122

00-15438

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN WYSE BLUCHER JR.			2a. DATE OF DEATH MONTH DAY YEAR 8 13 86			2b. HOUR 8 A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing		
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Edwin E. Blucher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Goshell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-1980	
17. INFORMANT Box 148-412 Cherry Oak Court Flora E. Blucher Taneytown, Md. 21787										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>end stage COPD</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>congestive heart failure, ASH D</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> , 19 <u>86</u> , to <u>8/13</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8/13</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Park W. Espenschade Jr.</u> DEGREE						22c. DATE SIGNED 8/13/86		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park W. Espenschade Jr. M.D.		
22e. ADDRESS 419F Malcolm Dr., Westminster, Md. 21157										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/16/86		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.		
24. FUNERAL DIRECTOR NAME <u>B. Harry Bighting</u>			24b. ADDRESS Eckhardt Funeral Chapel Owings Mills, Md. 21117			25a. DATE REC'D. BY REGISTRAR AUG 15 1986		25b. REGISTRAR'S SIGNATURE <u>John W. ...</u>		

BP

Central

For delivery last hour, box 100

1000

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For delivery last hour, box 100

For delivery last hour, box 100

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23004
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELENORA VIRGINIA BLY		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 8 20 1986		2b. HOUR M 17 04
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11-24-30	6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH WOODBINE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 94 Woodbine Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper-Springfield Hospital
13a. STATE MARYLAND		13b. CITY OR TOWN CARROLL		13c. STREET ADDRESS 21771 2433 FLAG MARSH RD.
14. FATHER'S NAME FIRST MIDDLE LAST Thomas McDonaldson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Virginia Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-28-0468		17. INFORMANT Mr. Russell M. Bly, Jr.
		17. ADDRESS 21771 Rd		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SKULL FRACTURE - INTERNAL CHEST INJURIES 7289 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .		
ACTUAL SIGNATURE Daniel I. Welliver	TITLE (SPECIFY) AST DEP	DATE SIGNED 8-20-86
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER M.D.	M.D. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-23-86	23c. NAME OF CEMETERY OR CREMATORY Lake View memorial Park Eldersburg Carroll MD	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc		25. DATE REC'D. BY REGISTRAR AUG 22 1986	
ADDRESS 8728 Liberty Rd. Randallstown, MD 21133		25b. REGISTRAR'S SIGNATURE [Signature]	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD., 21201



10
6577STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH23005
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
Norman Dean Buckley								8/10/86				A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	Cauc.	11 7 66		19 YRS.		MONTHS DAYS HOURS MIN.				8/10/19 86		5:40 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
MD.		USA				Carroll County, MD							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Run		Rt. 97 & Silver Run Valley Rd.		Tree Trimmer		Trim							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MD.		Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		55 1/2 Liberty St 21157					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Norman Buckley		Nancy G. Rexroad											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS							
no		n/a		814-267-3252		Nancy R. Smith		13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atlanto-occipital Separation</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?									
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
4:12 PM		8/10/19 86		occupant of auto/fixed object collision									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
roadway		Rt. 97 & Silver Run Valley Rd., Carroll Co., Md											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY)		DATE SIGNED									
ACTUAL SIGNATURE		M.D. Assistant MEDICAL EXAMINER		8/10/86									
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.		ADDRESS		111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
burial		8/13/86		Meadow Branch		Westminster Carroll Md							
24. FUNERAL DIRECTOR NAME ADDRESS		PRITTS FUNERAL HOME		Westminster, Md		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
412 Wash. Rd						AUG 18 1986		Julia Sanders-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED OCT 20 1905

CHIEF OF BUREAU



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-1. RETAIN PAGE 6 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23006
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) WARREN BUDDINGTON			2a. DATE KNOWN OF DEATH ESTIMATED 8-6-86			2b. HOUR 1750		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 3 DAY 15 YEAR 19	6. AGE (IN YEARS) LAST BIRTHDAY 67 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN 	7c. DATE PRONOUNCED DEAD 8 6 19 86		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL		
11. CITY OR TOWN OF DEATH Taney Town		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3345 BERT KOONTZ RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Surveyor		12b. KIND OF BUSINESS OR INDUSTRY W.S.S.C.
13a. STATE MARYLAND			13b. COUNTY CARROLL	13c. CITY OR TOWN TANEYTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3345 BERT KOONTZ RD		
14. FATHER'S NAME FIRST MIDDLE unknown LAST 				15. MOTHER'S MAIDEN NAME FIRST Ruth MIDDLE LAST (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Box 62 Route 1 Wallace Buddington Sharpsburg, Md. 21782			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) GASTRO ENTERITIS DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Daniel I. Welliver			TITLE (SPECIFY) DEP			DATE SIGNED 8-6-86		
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER			ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-12-86		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION CITY OR TOWN Beltsville COUNTY Prince George's STATE Md		
24. FUNERAL DIRECTOR F. Gasch's Sons Funeral Home				25a. DATE REC'D. BY REGISTRAR AUG 8 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson Handall		
				25c. ADDRESS Hyattsville, Md. 20781				

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ACUTE CARDIO PULMONARY DISTRESS
GASTRIC DISTRESS

THOMAS I. WELLS
1000 N. W. 10th St.
WESTMINSTER, COLO. 80031

00-81682

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 23007

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Esther N.M.N. Chambers</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8-16-86</i>		2b. HOUR MIN. <i>1100A</i>					
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 25 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>86</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York City NY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>446 E. Saw Mill Rd (home)</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ARTIST</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>DOMESTIC</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD.</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>446 E. Saw Mill Rd. 21157</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Reuben N.M.N. Shemitz</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>RAHEL UNKNOWN Shemitz</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <i>215 46 7356</i>		17. INFORMANT NAME ADDRESS <i>John Chambers 2802 13th St NW, Wash DC</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1984</i> to <i>August 1986</i> , that (I) (we) last saw the deceased alive on <i>8-11-86</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <i>John W. Middleton M.D.</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John W. Middleton</i>						22e. ADDRESS <i>625-G Crossroad Shopping Ctr Westminster Md 21157</i>				
23a. BURIAL, CREMATION, REMOVAL <i>CREMATION</i>			23b. DATE <i>Aug 17, 1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CARROLL CREMATORY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>HANOVER CARROLL MD.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Robert A. Myers 91 Wallis St. Baltimore</i>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>AUG 21 1986 Julia Henderson-Rudman</i>				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 8 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible handwritten text covering the page]

00-81745

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 3 0 0 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irene Clark			2a. DATE OF DEATH MONTH DAY YEAR 8-25-86			2b. HOUR 12:05 (M)			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR July 20, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH MT. AIRY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PLEASANT VIEW NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST EMMETT McCUEN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE ANGERER			13e. STREET ADDRESS / ZIP CODE 5308 Overhill Rd. Balt. 21207			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-8158A		17. INFORMANT ADDRESS Irene C. Foster, same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC cardiac disease + Atrial Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) General Atherosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Alzheimers, CVA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, BANK, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 4/19 19 86 to 8/21 19 86 , that (I) (we) last saw the deceased alive on 8/21 19 86 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Melvin J. Kordon			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Kordon			22e. ADDRESS 2000 Century Plaza Columbia MD 21044						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-28-86		23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wicomico, Md.		
24. FUNERAL DIRECTOR NAME CURRAN FUNERAL HOME, CAMBRIDGE, MD.			ADDRESS 308 High St.		25a. DATE REC'D. BY REGISTRAR SEP 2 1986		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

00-01242

00-15128

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23009
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ROBERT LEWIS COHEN			7a. DATE KNOWN OF DEATH ESTIMATED 8 10 1986		7b. HOUR 5
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 9 DAY 17 YEAR 1928	6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		7c. DATE PRONOUNCED DEAD 8 10 1986	
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2612 BARNEZ LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN	
13a. STATE MARYLAND		13b. COUNTY CARROLL	13c. CITY OR TOWN SYKESVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2612 BARNEZ LANE
14. FATHER'S NAME FIRST SYLVAN MIDDLE COHEN LAST COHEN			15. MOTHER'S MAIDEN NAME FIRST MIRIAM MIDDLE BIRNBAUM LAST BIRNBAUM		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-22-1363		17. INFORMANT JEAN STARK 2 DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN LACERATION & CONTUSION DUE TO, OR AS A CONSEQUENCE OF SKULL FRACTURE (b) SELF INFLICTED WOUND DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Daniel I Welliver		TITLE (SPECIFY) AST. DIR.		DATE SIGNED 8/10/86	
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I WELLIVER		ADDRESS 218 WASHINGTON HEAVENLY WESTMINSTER MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 8-12-86	23c. NAME OF CEMETERY OR CREMATORY CARROLL CREMATION SERV.		23d. LOCATION CITY OR TOWN COUNTY STATE HAMPSTEAD CARROLL MD.	
24. FUNERAL DIRECTOR NAME HEBREW MEMORIAL F.H.		ADDRESS PIKESVILLE, MD 21208		25a. DATE REC'D. BY REGISTRAR AUG 13 1986	25b. REGISTRAR'S SIGNATURE John Davidson

208 COTTON + 1500

121



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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 6

23010

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ROBERT Peree DEVILBISS			2a. DATE OF DEATH MONTH 8 DAY 13 YEAR 86			2b. HOUR 3 MIN. AM			
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH 6 DAY 20 YEAR 1902		6 AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY Shoe Factory	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13a COUNTY Carroll 13a CITY OR TOWN Hampstead					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE 1811 Albert Rill Rd. 21074		
14 FATHER'S NAME FIRST Edward MIDDLE Devilbiss LAST Devilbiss			15 MOTHER'S MAIDEN NAME FIRST Emily MIDDLE Caples LAST Caples						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 213-05-1592		17 INFORMANT Helen Farver ADDRESS 4703 Ridge Rd. Mt. Airy, Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIO - PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF ASTHMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY FIBROSIS									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8-13-86 to 8-13-86 , that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE N. RA JPA RA M.D.					DEGREE MD		22c. DATE SIGNED 8-13-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. RA JPA RA M.D.					22e. ADDRESS 224 WASHINGTON HTS. WESTMINSTER				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-15-86		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION CITY OR TOWN Westminster COUNTY Carroll STATE MD.		
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son			24b. DATE REC'D. BY REGISTRAR 8-15-86		25b. REGISTRAR'S SIGNATURE [Signature]				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-14817

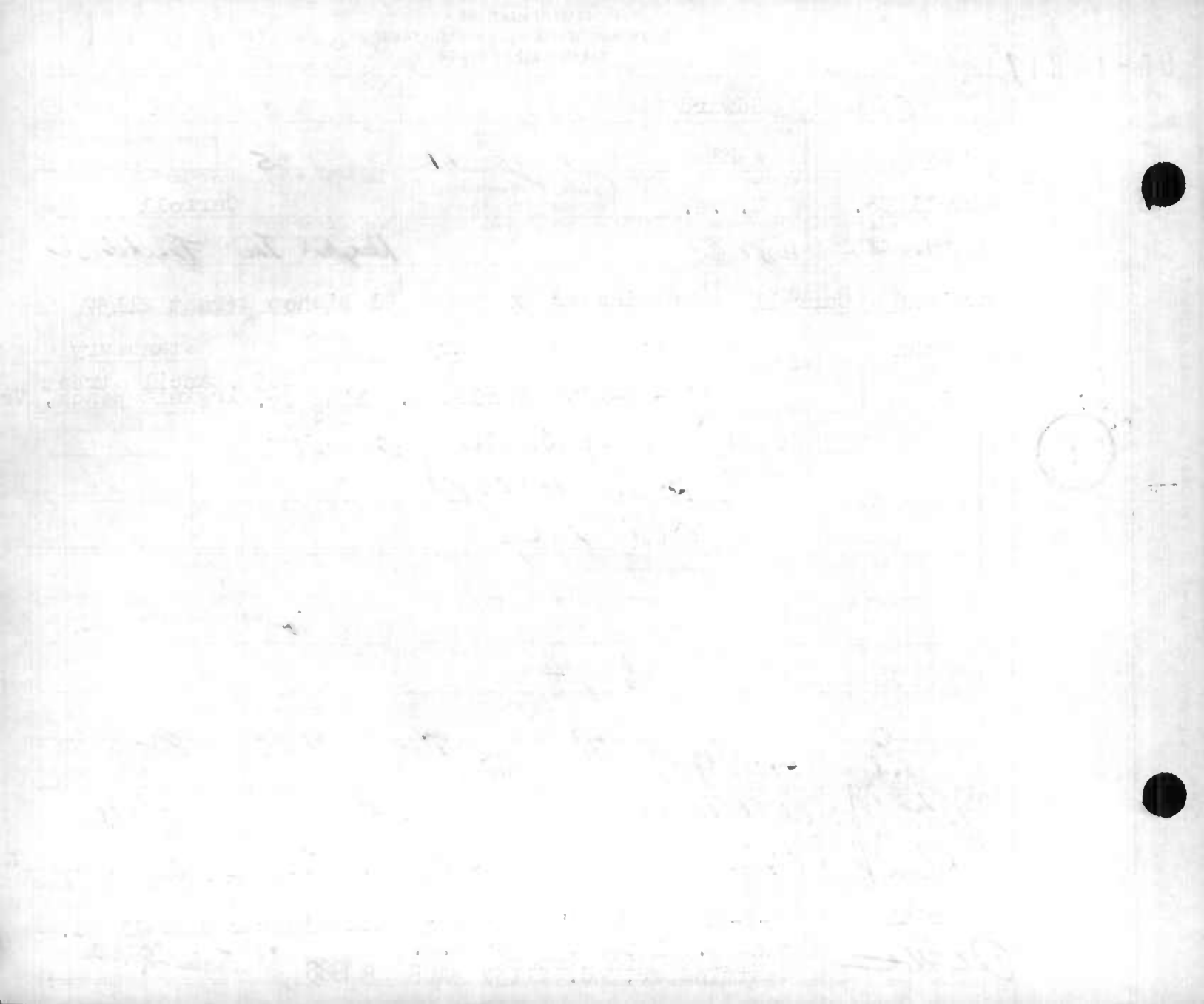
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 23011

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles Edward Eline</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8/5/86</i>		2b. HOUR <i>5:45 PM</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 14 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <i>Carroll Co.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.	
10. CITY OR TOWN OF DEATH <i>Westminster</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WRCC</i>			12a. USUAL OCCUPATION (IF PLACE OF WORK FOR MOST OF WORKING LIFE) <i>Wheeler's Inc</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Truckdriver</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>			13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Eline</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Stansbury</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-09-1833</i>		17. INFORMANT ADDRESS <i>Charles E. Eline Jr. 285 Stancil Street Virginia Beach, Va 23452</i>	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Old age</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>11 12 86</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3/1</i> , 19 <i>86</i> , to <i>8/5</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>7/13/86</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)					
22b. SIGNATURE <i>John M. Sullivan MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>8/5/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John M. Sullivan</i>		22e. ADDRESS <i>6256 Cornwall Shopping Center Westminster</i>			
23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i>		23b. DATE <i>8-9-86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Krider's Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westminster Carroll Md.</i>
24. FUNERAL DIRECTOR NAME <i>Cal Hot</i>		25. DATE REC'D. BY REGISTRAR <i>8 1986</i>		26. REGISTRAR'S SIGNATURE <i>John Sullivan</i>	



00-15983

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

6 23012

1. DECEASED NAME (TYPE OR PRINT) Anna BEATRICE Eutsler			2a. DATE OF DEATH MONTH DAY YEAR 8/3/86			2b. HOUR 8:49 M			
3. SEX Female		4. RACE Can.		5. DATE OF BIRTH MONTH DAY YEAR 10 24 27		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 8 13 12	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PACKER		12b. KIND OF BUSINESS OR INDUSTRY ELECTRONIC	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN FINKSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST TRUMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HILDA BOVERSOX		13e. STREET ADDRESS / ZIP CODE 3947 SYKESVILLE RD. 21048 FINKSBURG					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CarcinomatosisAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4r**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Carcinoma Breast****4r**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

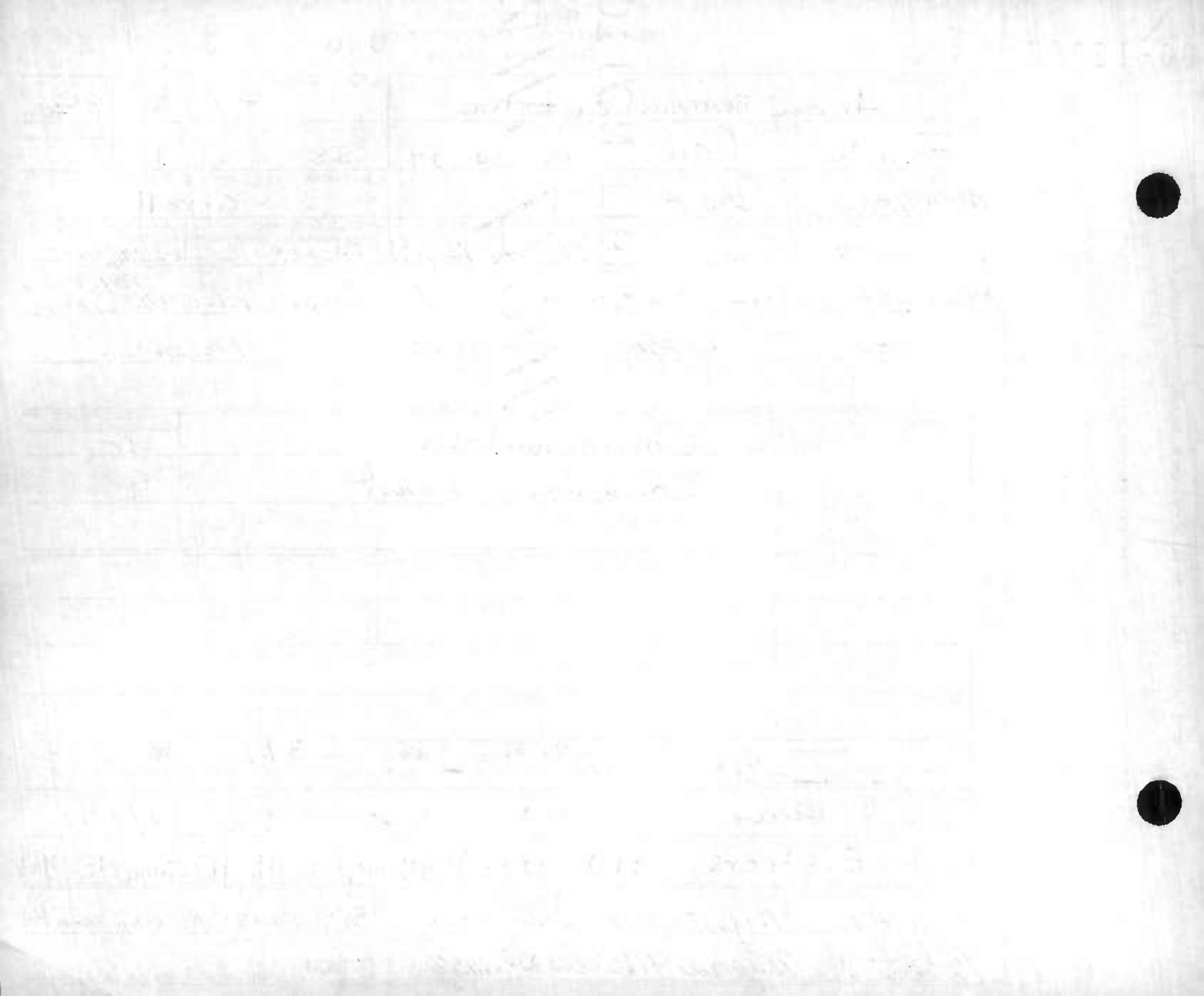
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 7/31 , 19 86 , to 8/3 , 19 86 , that (I) (most) saw the deceased alive on 8/2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John E. Steers		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Steers		22e. ADDRESS 222 Washington Ht, Westminster, Md.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE August 6, 1986		23c. NAME OF CEMETERY OR CREMATORY BEAVER CREEK		23d. LOCATION CITY OR TOWN COUNTY STATE BRIDGEWATER ROCKINGHAM VA.	
24. FUNERAL DIRECTOR Robert A. Myers				25a. DATE REC'D. BY REGISTRAR 2115706 12 1986			
25b. REGISTRAR'S SIGNATURE John Steers							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



-16280

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23013
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH GEORGE FLINT		2a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 1986 30	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 1928	6. AGE (IN YEARS) 58 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD	
10. CITY OR TOWN OF DEATH MANCHESTER		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2966 MANCHESTER BAPTIST CHURCH RD, MANCHESTER, MD	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND CARROLL		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER PETROLEUM	
13a. CITY OR TOWN MANCHESTER		13b. STREET ADDRESS BAPTIST CHURCH ROAD	
14. FATHER'S NAME FIRST JOSEPH MIDDLE GEORGE LAST FLINT		15. MOTHER'S MAIDEN NAME FIRST MARIE MIDDLE GANSHORN LAST GANSHORN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-20-0710	
17. INFORMANT DELORIS FLINT		ADDRESS MANCHESTER BAPTIST CHURCH RD, MANCHESTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE Daniel I. Welliver MD		TITLE (SPECIFY) ASST DIR	
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD		DATE SIGNED 8-22-86	
ADDRESS 210 WASHINGTON AVE #47 WESTMINSTER, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/25/86	23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM PARK	23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE HOWARD MD
24. FUNERAL DIRECTOR Ray Hightower		DATE REC'D. BY REGISTRAR AUG 26 1986	
25a. REGISTRAR'S SIGNATURE Ray Hightower		25b. REGISTRAR'S SIGNATURE Ray Hightower	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 38 checked, any injury, or other traumatic event, the medical examiner must be notified at once.

DMMH - 16 60M 7/B4
(VRA 15, 4)

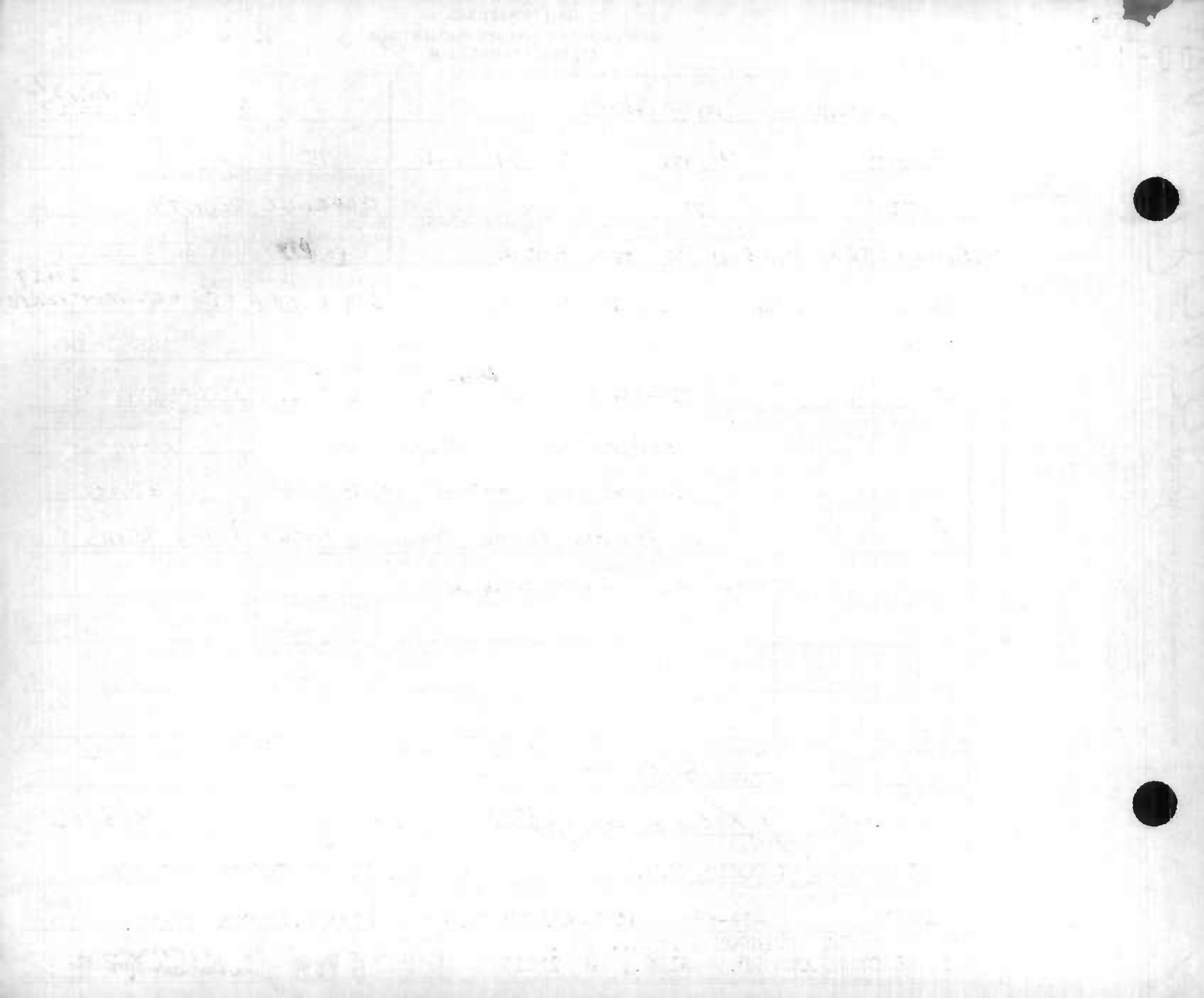
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DR. <u>GERTRUDE MAY GROSS</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>8 8 86</u>			2b. HOUR <u>10:23 P.M.</u> <u>22:23 M.</u>			
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3 21 11</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>GERMANY</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>CARROLL COUNTY</u> MD.			
10. CITY OR TOWN OF DEATH <u>WESTMINSTER</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>CARROLL CO. GEN HOSP.</u>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <u>CHIATRIST</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>MEDECINE</u>	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>CARROLL</u>		13c. CITY OR TOWN <u>WESTMINSTER</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>334 E. MAIN ST - WESTMINSTER MD</u> <u>21157</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>SIMON MAY</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>CECILIA ASSENHEIM</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>219-36-1800</u>		17. INFORMATION <u>DR. STEVEN THOMAS GROSS</u>		ADDRESS <u>#21043</u>		9305 MEADOW HILL RD., ELLICOTT CITY, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL RUPTURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC CORONARY HEART DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>IMMED.</u> <u>3 DAYS</u> <u>YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ESSENTIAL HYPERTENSION</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> , 19 <u>86</u> , to <u>8/8</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>8/8</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Vincent J. Picoccio</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8/8/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>VINCENT J. PICOCIO, M.D.</u>				22e. ADDRESS <u>CARROLL COUNTY GENERAL HOSPITAL</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>8-11-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHEVRA AHAVAS CHESD</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>RANDALLSTOWN BALTO. MD</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>SOL LEVINSON & BROS., INC.</u> <u>6010 REISTERSTOWN RD., BALTO., MD 21215</u>						25a. DATE RECEIVED BY REGISTRAR <u>AUG 15 1986</u>			
						25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP.



00-14916

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (15))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23015
REG NO1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) H L D A M A E H A L L						2a. DATE KNOWN OF DEATH 8 10 19 86		2b. HOUR 6 00 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 10 26 19 86		6. AGE (IN YEARS) 8 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? UNITED STATES		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
12. CITY OR TOWN OF DEATH MILLERS		13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3500 YOUNG ROAD				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY CARROLL 13c. CITY OR TOWN MILLERS						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3500 YOUNG ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST Lee A. McGee				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Hosfeld		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			
16a. SOCIAL SECURITY NO. 217-12-1460				17. INFORMANT Mrs. Regina Rill, Westminster, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 15 YEARS									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Daniel J. Welliver				TITLE (SPECIFY) M.D. ASST. DIR.		DATE SIGNED 9-10-86		MEDICAL EXAMINER 210 WASHINGTON ST. N.W. WESTMINSTER MD	
EXAMINER'S NAME (TYPE OR PRINT) DANIEL J. WELIVER				ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-13-86		23c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.				25a. DATE REC'D. BY REGISTRAR AUG 11 1986		25b. REGISTRAR'S SIGNATURE John J. Jordan			

1. The first part of the report is a general
 description of the project and its objectives.
 It includes a brief history of the project and
 a statement of the purpose of the study.

2. The second part of the report is a detailed
 description of the methodology used in the study.
 It includes a description of the data collection
 methods and the statistical analysis used.

3. The third part of the report is a discussion
 of the results of the study. It includes a
 comparison of the results with the objectives of
 the study and a discussion of the implications
 of the findings.

4. The fourth part of the report is a conclusion
 and a list of references. It includes a summary
 of the main findings of the study and a list of
 the sources used in the research.

0-16616

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 23016

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH R. HANSSEN			2a. DATE OF DEATH MONTH DAY YEAR 8 27 86			2b. HOUR 11:30 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 - 16 - 08		6. AGE (IN YEARS (LAST BIRTHDAY)) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Staley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Freda Weiner		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 215 32 1371		17. INFORMANT ADDRESS Betty L. Klatzkin 6216 Rolling View Drive Sykesville, MD 21784					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

circulatory failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerotic Heart Disease

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

Breast cancer

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/22/1986 to 8/27/1986, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Vimala N. Naganna		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/27/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA N. NAGANNA		22e. ADDRESS 700A POOLE RD, WESTMINSTER MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-29-86		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore MD	
24. FUNERAL DIRECTOR NAME ADDRESS HAIGHT FUNERAL HOME SYKESVILLE, MD 21784				25a. DATE REC'D. BY REGISTRAR AUG 28 1986		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



0-16203

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 23017

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MILDRED Leona HENTZMAN			2a. DATE OF DEATH MONTH DAY YEAR 08 22 86			2b. HOUR 8 15 A.M.	
3. SEX FEMALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 10 28 03		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Westminster Nursing & Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		
14. FATHER'S NAME FIRST MIDDLE LAST James Buckingham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Criswell			16. STREET ADDRESS / ZIP CODE 113 East Green Street 21157	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-56-5336		17. INFORMANT Margaret Staton 113 East Green Street Westminster, Md. 21157			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: b) <u>Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF: c) <u>CVT</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NATURE OF ACCIDENT) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> OR WHILE AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/17/85, 19, to 8/22, 19, that (I) saw the deceased alive on 8/22, 19, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE John W. Middleton MD				DEGREE		22c. DATE SIGNED 8-22-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Middleton MD				22e. ADDRESS 6256 Crosswood Shopping Center Westminster Md 21157			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-25-86		23c. NAME OF CEMETERY OR CREMATORY Messiah Lutheran		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. 254 East Main Street Westminster, Md. 21157				25a. DATE REC'D. BY REGISTRAR AUG 25 1986			

110. HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return these completed papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT. If item 21 is marked, item 21 shows any injury, or other traumatic event, the medical examiner must be notified.



0-1111



Handwritten text, possibly a signature or date, in the center of the page.

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0-14375

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

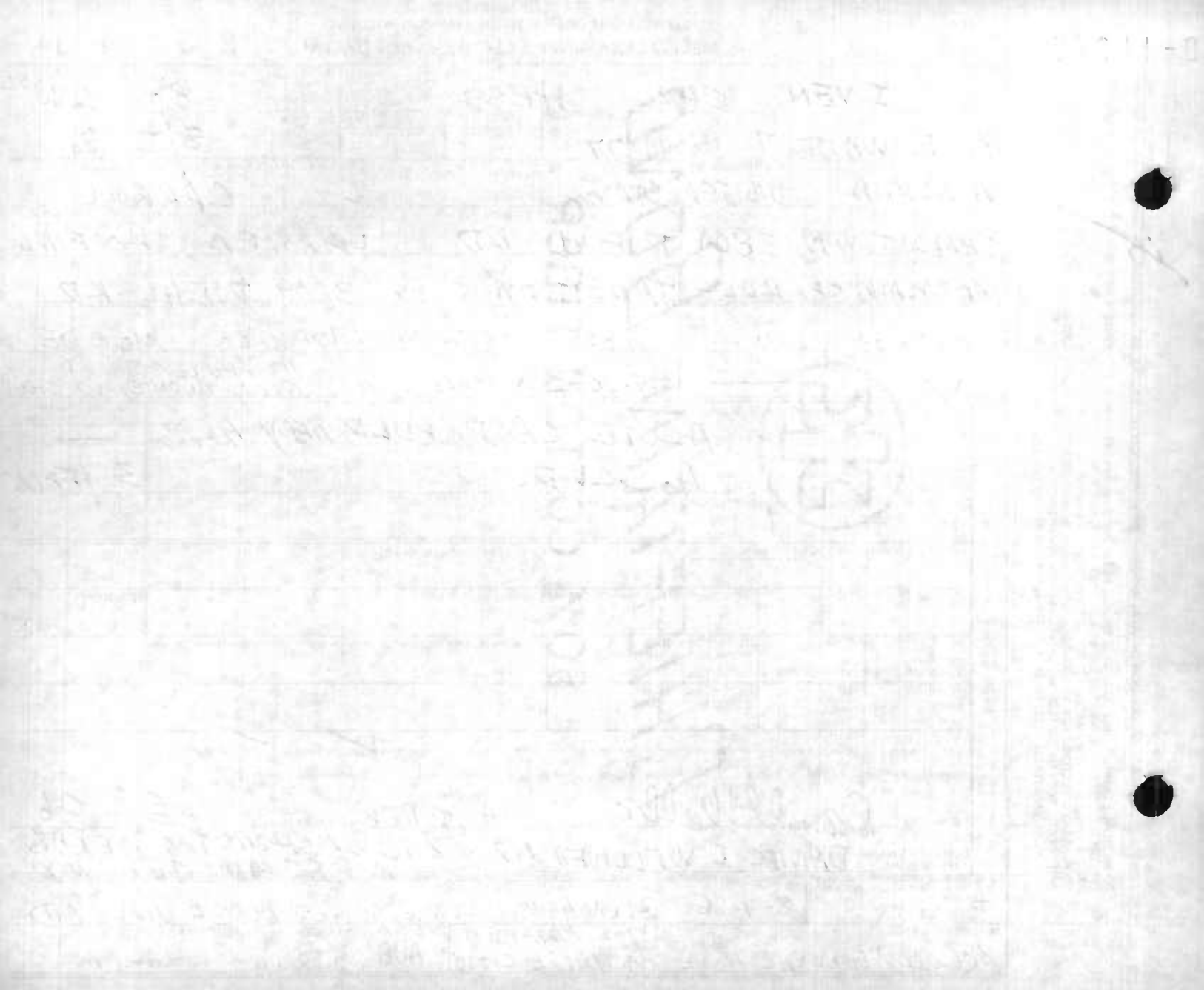
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 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REC. NO. 23018

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVEN CARL HESS			7a. DATE KNOWN OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 8/2 1986			7b. DATE OF DEATH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 8/2 1986		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 7 15 09 77	6. AGE (IN YEARS) LAST BIRTHDAY <input type="checkbox"/> YRS. 77	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 8/2 1986		7d. HOUR <input type="checkbox"/> M <input type="checkbox"/>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.		
10. CITY OR TOWN OF DEATH TANEY TOWN		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3804 DIEHL RD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY ROOFING	
13a. STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN TANEY TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST GEORGE MIDDLE W. LAST HESS			15. MOTHER'S MAIDEN NAME FIRST MAGGIE MIDDLE WOMPER LAST MEADE		16. SOCIAL SECURITY NO. 224-20-2518			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 224-20-2518		17. INFORMANT CARL A. HESS ADDRESS 112 MARLEY STA. RD GLEN BURNIE, MD 21061			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) A. S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Daniel I Welliver			TITLE (SPECIFY) ASST DEP			DATE SIGNED 8-2-86		
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I WELLIVER MD			ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-7-86		23c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN MEM. GDS		23d. LOCATION CITY OR TOWN GLEN BURNIE COUNTY A.A. STATE MD		
24. FUNERAL DIRECTOR NAME McCULLY FUNERAL HOME ADDRESS 237 E. PATAPSCO BALTIMORE 21225			25a. DATE REC'D. BY REGISTRAR AUG 5 1986		25b. REGISTRAR'S SIGNATURE John Davidson			



00-14888

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 92 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES Edgar HOCKENSMITH			2a. DATE OF DEATH MONTH DAY YEAR 8-3-86			2b. HOUR 0810M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 12 30 99		6. AGE (IN YEARS LAST BIRTHDAY) 86		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2405 Crouse Mill Rd./21787	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Robert Hockensmith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Boyd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-36-4633		17. INFORMANT ADDRESS Mrs. Kathryn Hockensmith Taneytown, MD 21787					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: Chronic obstructive lung disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 7-25-1986 to 8-3-1986 , that (I) (we) last saw the deceased alive on 8-2-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Chitra Chetdu NAGANNA				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRA CHETDU NAGANNA				22e. ADDRESS 700 Apple Rd. Westminster MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 6, 1986		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, Maryland			
24. FUNERAL DIRECTOR NAME Skiles Funeral Home				136 E. Baltimore St. Taneytown, MD 21787		25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 06 1986 Julia D. [Signature]			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Thelma Virginia Houck</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Aug 25 1986</i>			2b. HOUR <i>3:10 P.M.</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 19 14</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS <i>1 6</i>		IF UNDER 24 HRS HOURS MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bookkeeper</i>			12b. KIND OF BUSINESS OR INDUSTRY <i></i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13a. COUNTY <i>Carroll</i> 13a. CITY OR TOWN <i>Sykesville</i>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <i>593 Noland Dr. 21784</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Chaney</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha Shaw</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>212-30-0768</i>		17. INFORMANT ADDRESS <i>Elmer B. Houck, Same As #13</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIOPULMONARY ARREST</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>BACTERIAL MENINGITIS</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>DIABETES MELLITUS / HYPOALBUMINEMIA</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i></i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/21</i> 19 <i>86</i> to <i>8/25</i> 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>8/25</i> 19 <i>86</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Arthur J. Comant</i> MD				DEGREE				22c. DATE SIGNED <i>8/25/86</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur J. Comant</i> MD				22e. ADDRESS <i>1702 Liberty Rd. Eldersburg, Md. 21784</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>8-28-1986</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md.</i>			
24. FUNERAL DIRECTOR <i>Charles W. Burrier, Jr., Sykesville, Md.</i>						25. DATE REC'D BY REGISTRAR 25a. REGISTRAR'S SIGNATURE <i>AUG 27 1986 John Davidson-Randall</i>					

BP

REG. NO.

MEDICAL CERTIFICATION

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0-14765

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Delores L LeBrun			2a. DATE OF DEATH MONTH DAY YEAR 8-5-86			2b. HOUR 1604 M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 5 30		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6346 Barnett Avenue 21784	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -0-		17. INFORMANT ADDRESS 1036 Punjab Drive Mrs. Margaret A. Havelin Essex, MD 21221			

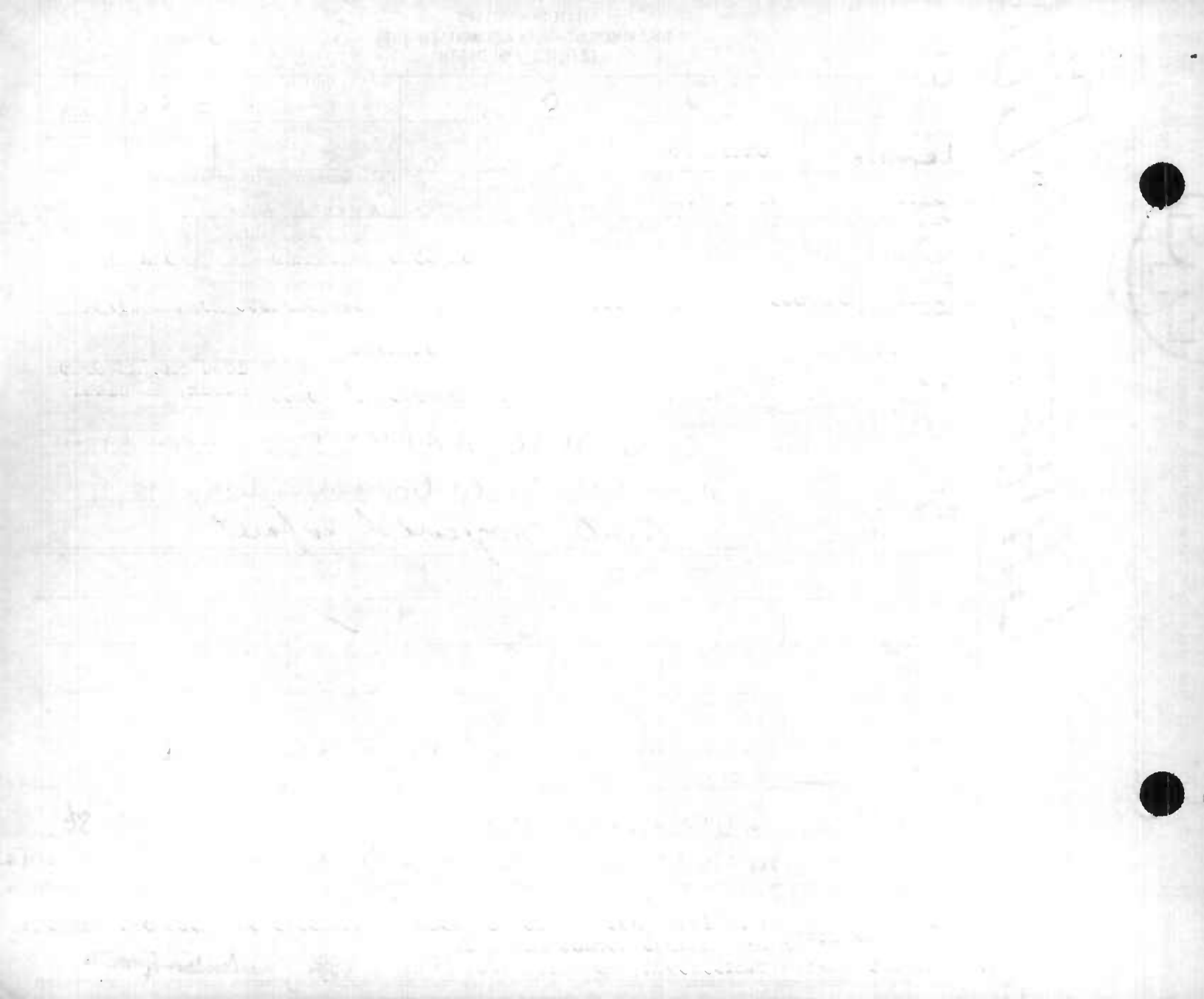
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Atherosclerotic cardiovascular disease		
DUE TO, OR AS A CONSEQUENCE OF (c) Acute myocardial infarct		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **0**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-25-1985 , to 8-5-1986 , that (I) (we) lost saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Christina Delores LeBrun				DEGREE MD		22c. DATE SIGNED 8/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHRISTINA DELORES LEBRUN				22e. ADDRESS 700 A pool Rd. Westminster MD 21157			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Aug. 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Holy Family Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randallstown Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, INC. ADDRESS 8728 Liberty Road Randallstown, MD 21133-4784				25a. DATE REC'D. BY REGISTRAR AUG 8 1986			
25b. REGISTRAR'S SIGNATURE Alie Davidson-Randall							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH6 2 3 0 2 3
REG. NO.1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ethel V. LEISTER			2a. DATE OF DEATH MONTH 8 DAY 23 YEAR 86			2b. HOUR M AM					
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH 2 DAY 15 YEAR 98		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home			
13a. STATE MD.			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Timber Ridge 21157		
14. FATHER'S NAME FIRST Noah MIDDLE Cutsail LAST Cutsail				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE E. LAST Strine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. na		17. INFORMANT Donald Leister		ADDRESS Westminster, Md. 21157		17. INFORMANT 375 N. Colonial Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH YEARS		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur L. Rudolph, MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/23/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L. RUDOLPH, MD						22e. ADDRESS WESTMINSTER, MD. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/26/86		23c. NAME OF CEMETERY OR CREMATORY Taneytown Lutheran		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown Carroll MD.				
24. FUNERAL DIRECTOR NAME Robert G. Brith Jr. ADDRESS Westminster, Md.						25a. DATE REC'D BY REGISTRAR AUG 27 1986 25b. REGISTRAR'S SIGNATURE John Anderson-Hord					

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05-17701

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23024

1. DECEASED NAME (TYPE OR PRINT) Geraldine Gladys Lewis			2a. DATE OF DEATH MONTH DAY YEAR 08 - 23 - 86			2b. HOUR 1615 M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 09 - 09 - 38		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Education	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Hermit Dacota IAN Perry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christina Louise Walkup							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 234-58-0804		17. INFORMANT Melvin H. Lewis		18. ADDRESS 4750 Stonesifer Rd. Taneytown, MD 21787			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Complications with drug, painkillers, and alcohol</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastases</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>3 1/4 yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins	
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION 1982, 83, 84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cn f. Omy				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 19, 85</u> , to <u>23 Aug 86</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>23 Aug 86</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald D. Colker MD				DEGREE				22c. DATE SIGNED 23 Aug 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald D. Colker MD				22e. ADDRESS 222 Washington Heights Medford Center, Maryland, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 26, 1986		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hanover, York, Pennsylvania 21157			
24. FUNERAL DIRECTOR NAME Skiles Funeral Home				136 E. Baltimore St. Taneytown, MD 21787		25a. DATE REC'D. BY REGISTRAR AUG 27 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

0-14815

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 3 0 2 5

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Henry A. Little</i>			2a. DATE OF DEATH MONTH <i>8</i> DAY <i>5</i> YEAR <i>1986</i>			2b. HOUR <i>6 20 PM</i>			
3. SEX <i>male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>5</i> DAY <i>24</i> YEAR <i>97</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Custodian</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Telephone & Electronics</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Carroll</i> 13c. CITY OR TOWN <i>Westminster</i>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>15 Timber Ridge Drive 21157</i>		
14. FATHER'S NAME FIRST <i>John</i> MIDDLE <i>Little</i> LAST <i>Little</i>				15. MOTHER'S MAIDEN NAME FIRST <i>Elizabeth</i> MIDDLE <i>Whitten</i> LAST <i>Whitten</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <i>WW I Army</i>		17. INFORMANT <i>Robert Little</i>		27. ADDRESS <i>29 Sheffield Lane Northport, N.Y. 11768</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>DEBILITATION</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ADENOCARCINOMA UNKNOWN PRIMARY</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/27/86</i> , 19 <i>8/5/86</i> , 19 <i>8/5/86</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>8/5/86</i> , 19 <i>8/5/86</i> , and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death)									
22b. SIGNATURE <i>Howard G. Latham, MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>8/5/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HOWARD G. LATHAM, MD</i>				22e. ADDRESS <i>215 WASHINGTON HOBBS RD CTY WESTMINSTER</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-8-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Memorial Gardens</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Finksburg Carroll Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Thomas D. Fletcher & Son</i>		25. ADDRESS <i>254 East Main Street Westminster, Md. 21157</i>		26. REC'D. BY REGISTRAR <i>8 1986</i>		27. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

RECEIVED



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23026

1. DECEASED NAME (TYPE OR PRINT) Howell Clarence Lovell			2a. DATE OF DEATH MONTH DAY YEAR Aug 29; 1986			2b. HOUR 1030 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1/27/1903		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.				
10. CITY OR TOWN OF DEATH New Windsor		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 222 Main St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Barber		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed		
13a. STATE Maryland					13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Dallas Lovell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Stonaker					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-18-0558		17. INFORMANT ADDRESS New Windsor, Md. Catherine F. Lovell 222 Main St.						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left hemiparesis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral atherosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Jan 1981</u> <u>Nov 1984</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>① Carcinoma colon ② abdominal aortic aneurysm</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. <u>2/5/63</u> <u>Now</u>				
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28/86</u> 19, to <u>Now</u> 19, that (I) (we) last saw the deceased alive on <u>8/28/86</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <u>J.H. Caricofe MD.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/29/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>J.H. CARICOFE MD.</u>						22e. ADDRESS <u>104 N. Main St. Union Bridge Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/86		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Linwood Carroll Md.				
24. FUNERAL DIRECTOR NAME D.D. Hartzler						ADDRESS New Windsor, Md.		25a. DATE REC'D. BY REGISTRAR SEP 2 1986		
						25b. REGISTRAR'S SIGNATURE <u>J. H. Caricofe</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		6 6 2 3 0 2 7 REG. NO.		1 DECEASED NAME (TYPE OR PRINT) <i>Edlen S. McCormick</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>AUGUST 26 1986</i>		2b. HOUR <i>7:28 PM</i>	
3. SEX <i>Female</i>		4 RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 17 94</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>92 (92)</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County MD.</i>			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Lutheran Village</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Management</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Business</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>Carroll Lutheran Village 21157</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Albertus L. Severns</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lillie Cherry</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT ADDRESS <i>Clifford C. McCormick, Jr. New Windsor, MD</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rt. hemiparesis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ONE Day</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>1 18 82</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>Now</i>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>104 N. Main St. Union Bridge, MD</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/25 1986</i> , to <i>Now</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>8/25 1986</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>J. H. Caricofe MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>8/26/86</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. H. CARICOFE M.D.</i>		22e. ADDRESS <i>104 N. Main St. Union Bridge, MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>8-30-86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>WASHINGTON D.C.</i>			
24. FUNERAL DIRECTOR NAME <i>HAIGHT FUNERAL HOME</i>				ADDRESS <i>SYKESVILLE, MD 21784</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 28 1986</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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COLON FIBER



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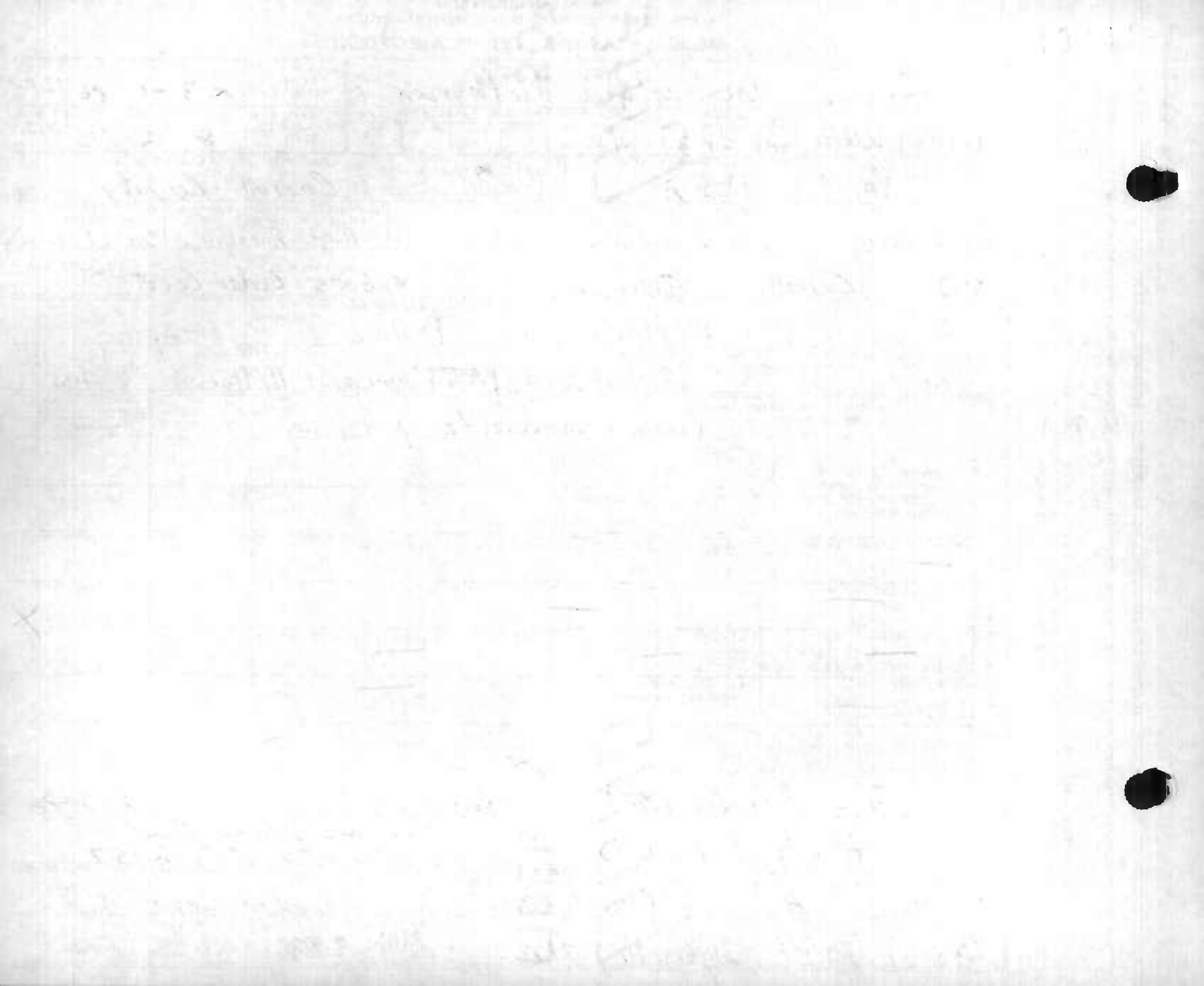
DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. FIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17
(VR A15 ME (5))
15M 7/76

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										23028 REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) George Washington McPherson Jr.										2a. DATE KNOWN OF DEATH 8-1-86		2b. HOUR 1300
3. SEX Male	4. RACE White	5. DATE OF BIRTH 09 21 37	6. AGE (IN YEARS) 48	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 8-2-86		2d. HOUR 0930				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County		MD.				
10. CITY OR TOWN OF DEATH Eldersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6005 Cedar Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mgt. Analysis		12b. KIND OF BUSINESS OR INDUSTRY Social Security				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Eldersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6005 Cedar Court				
14. FATHER'S NAME (TYPE OR PRINT) George W. McPherson Jr.				15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) Pauline Staples								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 227 48 3083		17. INFORMANT Mrs Margaret McPherson						
				ADDRESS Sykesville Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
(b)												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE Alva S. Baker MD		TITLE (SPECIFY) Asst Deputy Medical Examiner				DATE SIGNED 8-2-86						
EXAMINER'S NAME (TYPE OR PRINT) Alva S. Baker MD		ADDRESS 330-140 Village Road Westminster MD 21157										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-2-86		23c. NAME OF CEMETERY OR CREMATORY Carroll Union Burial		23d. LOCATION (CITY OR TOWN) COUNTY STATE Hampstead Carroll Md.						
24. FUNERAL DIRECTOR NAME Harry W. Hight ADDRESS Sykesville, Md.				25a. DATE RECD. BY REGISTRAR AUG 4 1986		25b. REGISTRAR'S SIGNATURE John S. Baker						



00-81749

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23029
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) KENNETH CLAUDE MILLER		2a. DATE KNOWN OF DEATH ESTIMATED 8-28-86		2b. HOUR 5A	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MAY 2 1918	6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Engineer Myers & Sons			
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER 34 LIBERTY ST		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND	13b. COUNTY CARROLL	13c. CITY OR TOWN WESTMINSTER	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 34 LIBERTY ST	
14. FATHER'S NAME FIRST MIDDLE LAST Bradley Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Taylor			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-07-9864		17. INFORMANT ADDRESS MARGARET MILLER WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ISCHEMIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MONTH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Daniel I. Welliver</i>		TITLE (SPECIFY) ASST. DEP.		DATE SIGNED 8-28-86	
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER		ADDRESS 218 WASHINGTON AVE. N.W. WESTMINSTER, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-31-86	23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.	
24. FUNERAL DIRECTOR NAME <i>Edith Fletcher</i>		25a. DATE REC'D. BY REGISTRAR SEP 2 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson Randall</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))

00-81742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

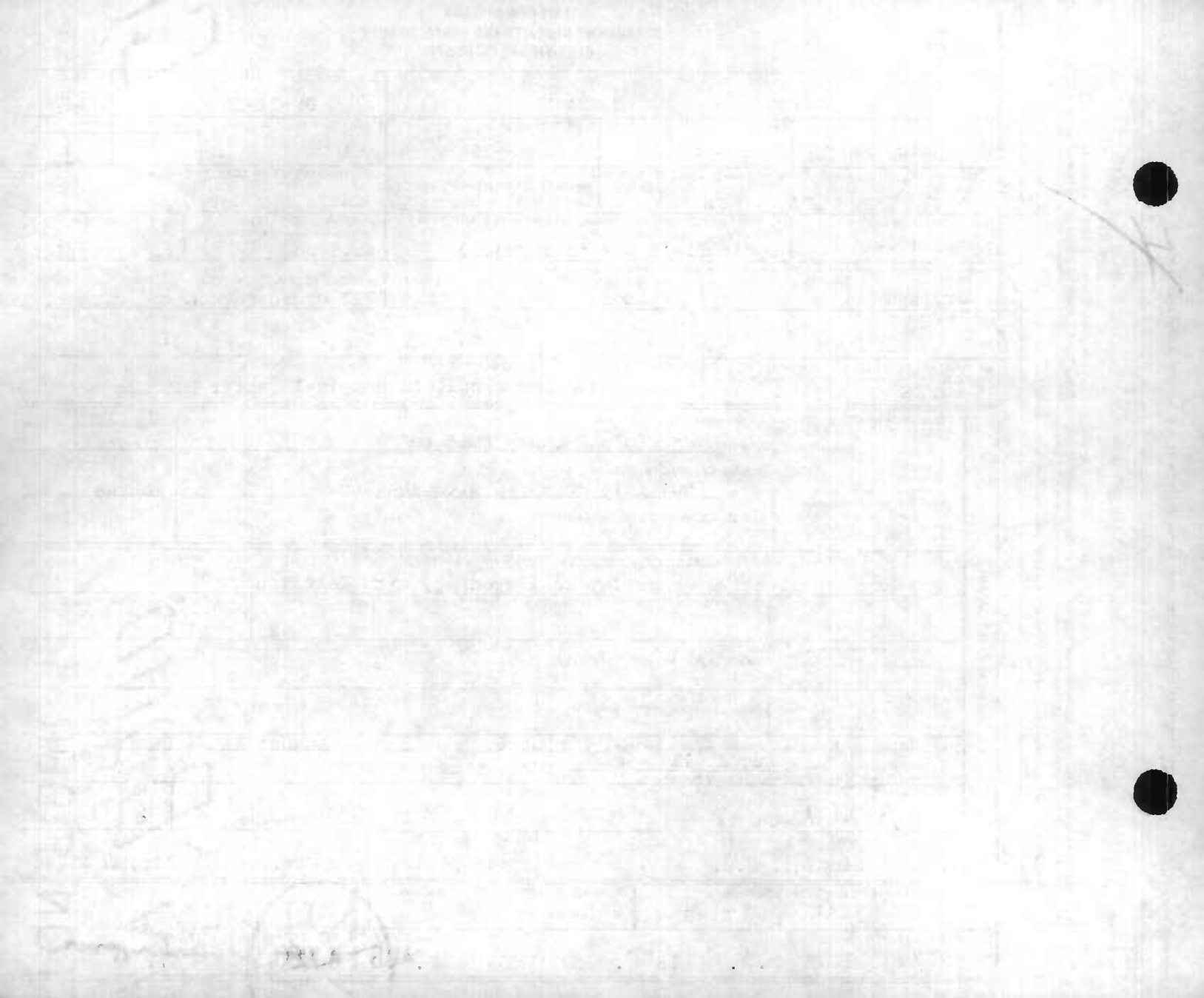
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		23. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		25. DATE REC'D. BY REGISTRAR	
1. DECEASED NAME (TYPE OR PRINT)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		25. DATE REC'D. BY REGISTRAR	
Alfred Moore		08-14-86		GARRISON FOREST		BALTIMORE, MARYLAND		AUG 14 1986	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		Black		02-18-95		91		12:45 A. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
NORTH CAROLINA		USA				Carroll County MD.		Retired construction	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE	
Sykesville		Springfield Hospital Center		Retired		construction		727 Druid Park Lake Dr., Apt. 11A	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21217	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
JOSEPH MOORE		SOPHIE ?		YES		214-09-1678		Springfield Hospital Center Records Sykesville, MD 21784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
IMMEDIATE CAUSE (a) Cardio pulmonary failure						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple decubiti with abscesses								Minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								Months	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
Primary degenerative dementia, senile onset, with delusions.									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
		HOUR A.M. MONTH DAY YEAR				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		CITY OR TOWN COUNTY STATE	
		P.M. 19							
22a. I certify that (I) (this hospital) attended the deceased from August 6, 1985, to August 11, 1986, that (I) (we) lost									
saw the deceased alive on August 11, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED	
S. Siddiqi		8/11		Shahida Siddiqi, M.D.		Springfield Hosp. Ctr., Sykesville, MD 21784			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED		22g. REGISTRAR'S SIGNATURE		22h. REGISTRAR'S SIGNATURE	
						J. Davidson			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		25. DATE REC'D. BY REGISTRAR	
BURIAL		08-14-86		GARRISON FOREST		BALTIMORE, MARYLAND		AUG 14 1986	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
BROWN/THOMPSON F.H. 1913 W. BALTIMORE ST.									

BP



00-15490

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transfer permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

66

23031

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEAMON Roy MUSICK			2a. DATE OF DEATH MONTH DAY YEAR 8/13/86			2b. HOUR 9.00 P.M.				
3. SEX male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4/12/96		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH carroll county MD.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) carroll county Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Virginia			13b. COUNTY Russell		13c. CITY OR TOWN Cleveland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Route 2 Box 89A 24226	
14. FATHER'S NAME FIRST MIDDLE LAST Fielding MUSICK			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Armalda Gilbert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 226-24-2459		17. INFORMANT ADDRESS Jeanne Musick 5055 S. Klee Mill Rd. Sykesville					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac arrest = atrial fibrillationAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4 years**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b) organic brain syndrome**4 years**

DUE TO, OR AS A CONSEQUENCE OF

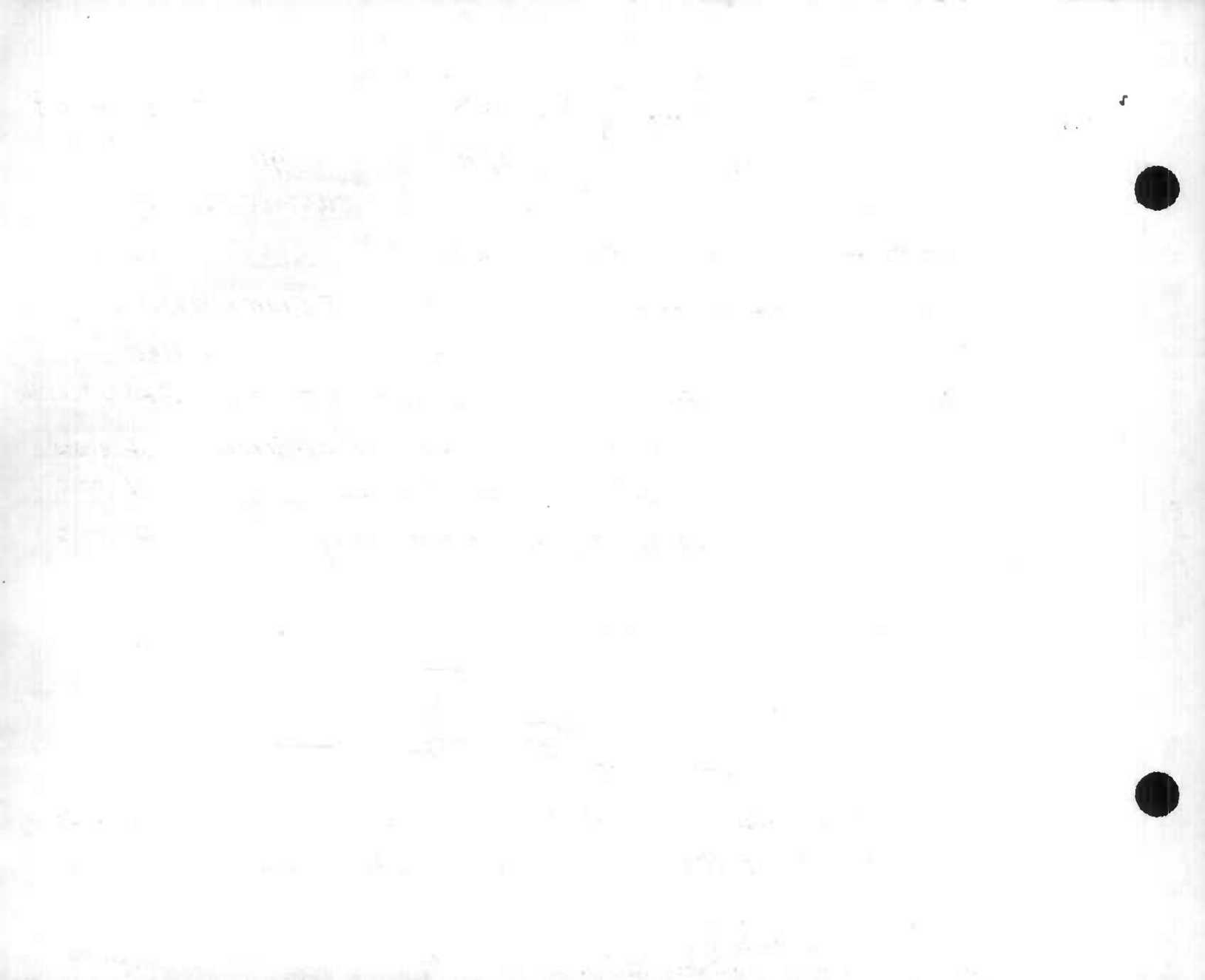
(c) cardiovascular accident history**4 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/10 , 19 82 , to 8/13 , 19 86 , that (I) (we) lost saw the deceased alive on 7/28 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Augustin Chyu				DEGREE M.D.		22c. DATE SIGNED 8/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AUGUSTIN I. CHYU				22e. ADDRESS 1948 Liberty Rd SYKESVILLE, MD 21784			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE August 14, 86		23c. NAME OF CEMETERY OR CREMATORY Fielding Musik Fam. Cem. Cleveland		23d. LOCATION CITY OR TOWN COUNTY STATE Russell Virginia	
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133				25a. DATE REC'D. BY REGISTRAR AUG 15 1986		25b. REGISTRAR'S SIGNATURE Twicken	

BP
DHMH 16 50M 4/83
(VRA 15, 4)



00-15617

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 3 0 3 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST <u>Reed Martha Idella Reed</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>8-15-86</u>			2b. HOUR <u>0701</u> M	
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>07 06 98</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>88</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll Co.</u> MD.	
10. CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll County General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Agent</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>MD</u>				13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Reisterstown</u>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE <u>1120 Old Westminster Pike 21136</u>			

14. FATHER'S NAME FIRST MIDDLE LAST <u>David Kibler</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Carrie Ruffner</u>	
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>218-32-2629</u>		17. INFORMANT <u>Erin Kibler</u>		ADDRESS <u>3272 Sykesville Rd. Westminster Md.</u>	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHUnknown

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerotic Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
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22a. I certify that (I) (this hospital) attended the deceased from 8/14/86 to 8/15/86, that (I) (we) last saw the deceased alive on 8/14/86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <u>Chitra Khetu Nae Anna</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/15</u>	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHITRA KHETU NAE ANNA</u>		22e. ADDRESS <u>700 A poole Rd. Westminster MD 21157</u>	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8-18-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beams Chapel</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Laray Virginia</u>	
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24. FUNERAL DIRECTOR NAME <u>Walter Funeral Home</u>		25. DATE REC'D. BY REGISTRAR <u>AUG 19 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson Henderson</u>	
--	--	--	--	---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, add completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

BP



CONFIDENTIAL (mirrored text)

CONFIDENTIAL (mirrored text)

00-14608

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

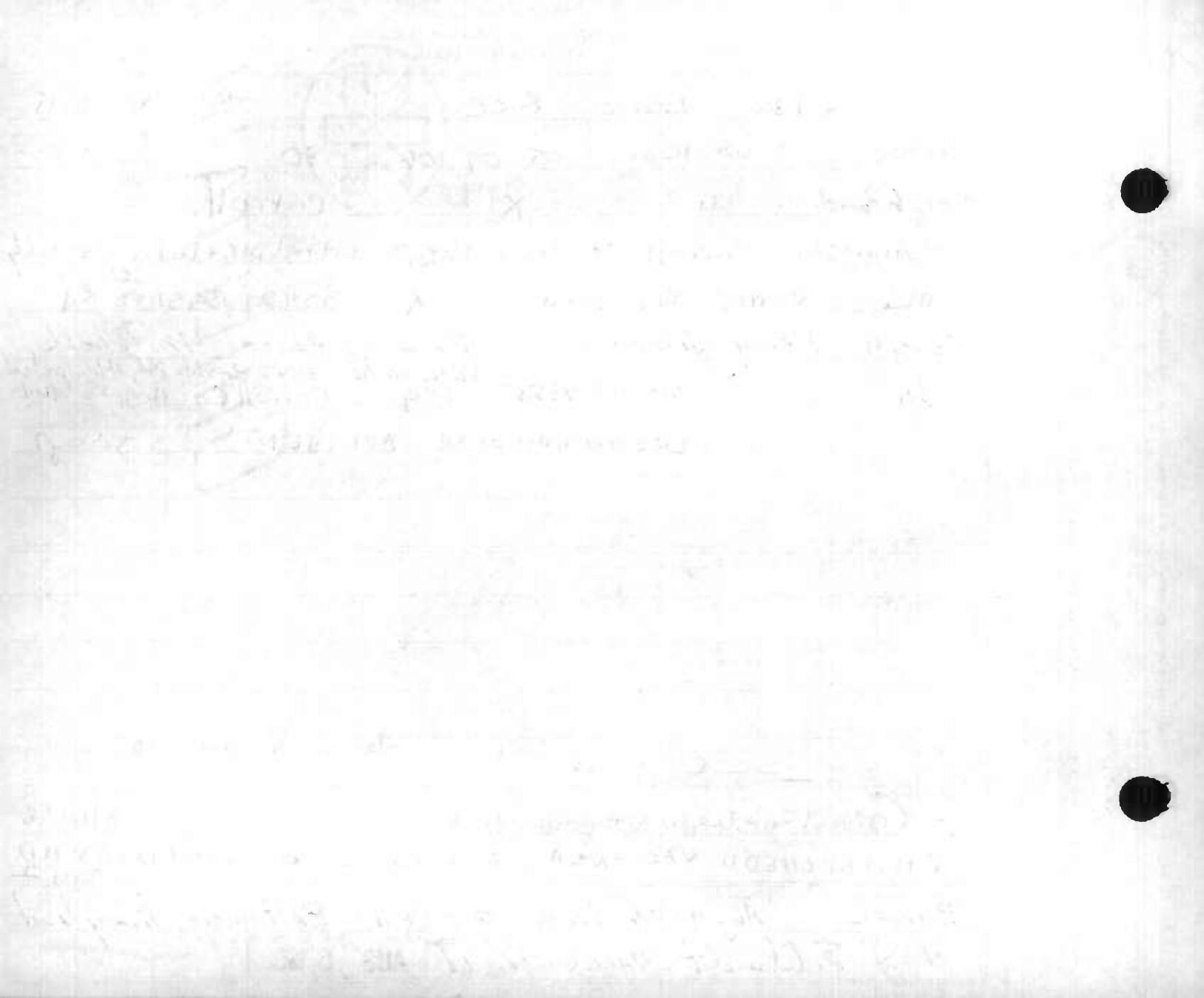
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23033

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hilda Louise Rice			2a. DATE OF DEATH MONTH DAY YEAR 8-4-86		2b. HOUR 1915 M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05 09 06	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.		
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FORMOST OF WORKING LIFE) Retired Bk + Decker Assembly		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md			13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Henry Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Alice Mitchell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-65-4355	17. INFORMANT NAME ADDRESS Ruth Auld 3546 Basler Rd, Hampstead NSG Carroll Co. Hosp. Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-1-86 to 8-4-86, that (I) (we) lost saw the deceased alive on 8-4-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE CHITRACHEDU MACANNA MD				22c. DATE SIGNED 8/4/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU MACANNA				22e. ADDRESS 700A POOLE Rd. WESTMINSTER MD 21152	
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE Aug. 7, 1986		23c. NAME OF CEMETERY OR CREMATORY London Park Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland		24. FUNERAL DIRECTOR NAME ADDRESS J. Ehlhardt 21109 Manchester, Md		25a. DATE REC'D. BY REGISTRAR AUG 5 1986	
25b. REGISTRAR'S SIGNATURE J. Ehlhardt					



BP

DHMH - 16 50M 1/81
(VRA 15, 4)

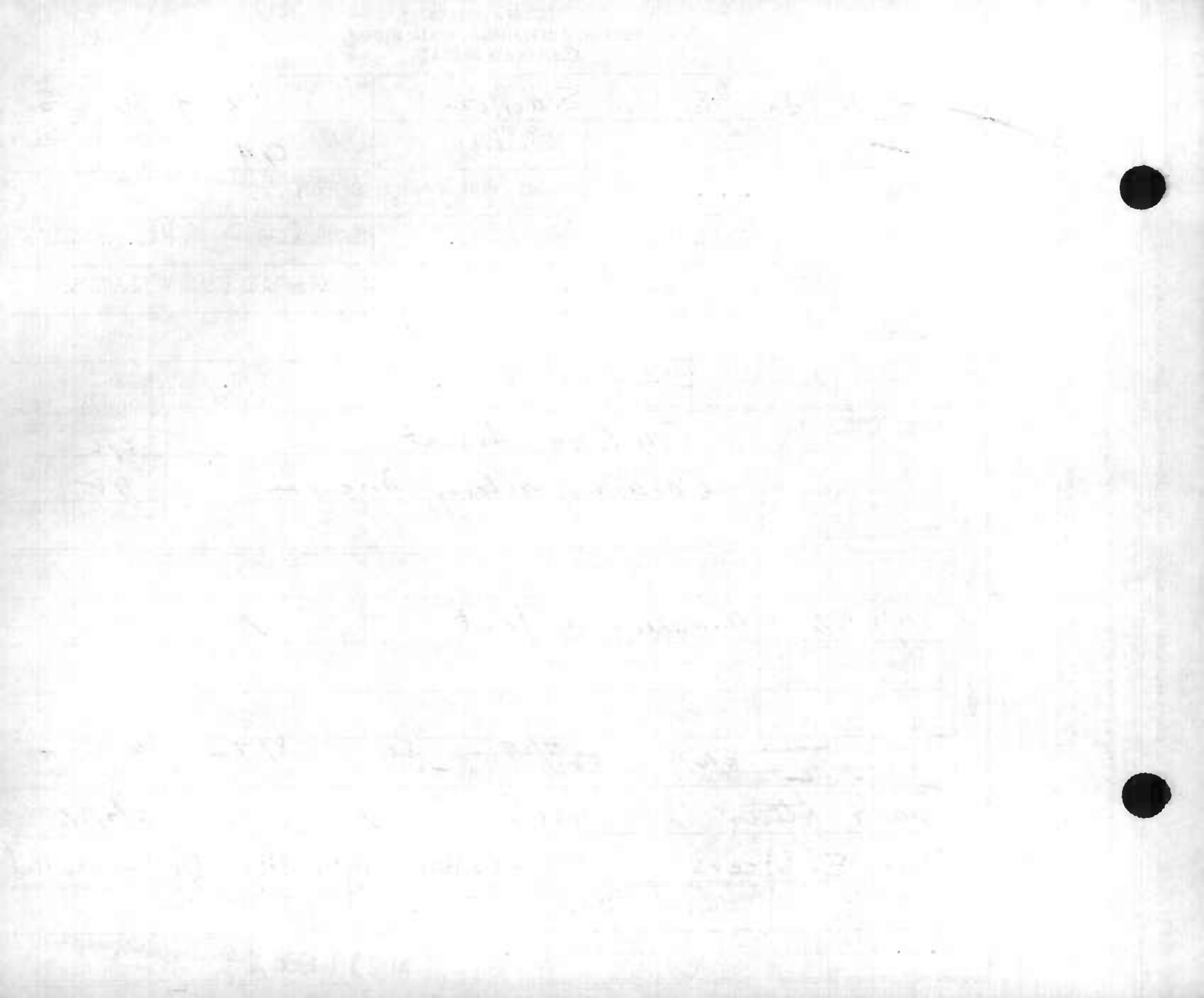
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		3. SEX				4. RACE			
HILDA S. Saylor		FEMALE				WHITE			
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. BALTIMORE CITY OR COUNTY OF DEATH			
12/11/91		94				CARROLL			
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
MARYLAND		U.S.A.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION (OF WORKING LIFE)			
WESTMINSTER		CARROLL COUNTY GENERAL HOSP.				SEAMSTRESS			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
CARROLL WESTMINSTER		UNKNOWN				MAY SINGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NONE		217-10-9874		HELEN P. GARBER		3 W. BROADWAY UNION BRIDGE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>								96	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Disease</u>								96	
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
7/31/86		Gangrene @ foot				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> 19 <u>86</u> to <u>8/7</u> 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>8/6/</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE				DEGREE				22c. DATE SIGNED	
John E. Steers				MD				8/7/86	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
John E. Steers				222 Washington Hts, Westminster					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
BURIAL		08/09/86		LUTHERAN CEMETERY, UNIO		UNION TOWN CARROLL MD STATE			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
D. D. HARTZLER				AUG 11 1986				John E. Steers	



00-16279

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23035
REG. NO.1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth M. Scheid		2a. DATE OF DEATH MONTH DAY YEAR Aug. 22, 1986		2b. HOUR 8:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 19, 1905	
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD			
10. CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2859 Benson Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE 2859 Benson Road 21048			
13b. CITY OR TOWN Md.		13c. COUNTY Carroll		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virgil Wagner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-74-7581		17. INFORMANT Susan White Bouden Finksburg, Md. 21048	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (a) Cardio pulmonary Arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. Alan Baldanza, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S TITLE (TYPE OR PRINT)				22e. ADDRESS 10629 York Rd., Cockeysville, Md. 21030			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Cremation		23b. DATE Aug. 23, 1986		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park Baltimore, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME R. A. Ehlhardt				ADDRESS Owings Mills, Md.		25a. DATE REC'D. BY REGISTRAR AUG 26 1986	
				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23036	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) OTTO (NMN) Schroder					2a. DATE OF DEATH MONTH DAY YEAR 8/3/86			2b. HOUR 7:38 AM			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 7 2 99		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST Julius Schroder					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katerina A. Mommsen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-14-5518		17. INFORMANT ADDRESS Robert F.W. Schroder, Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Transverse Colon cr. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH no		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD severe, Bronchitis severe											
19a. DATE OF OPERATION 7/23/86			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Obstruction Colon + duodenum			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 6/26 , 19 86 , to 8/3 , 19 86 , that (I) (not) last saw the deceased alive on 8/2 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Steers						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/3/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Steers						22e. ADDRESS 222 Washington Hts, Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-4-1986		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., Md.				
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.						25. DATE REC'D. BY REGISTRAR AUG 06 1986					
						26. REGISTRAR'S SIGNATURE Julia Dandrea-Rodach					

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00-15523

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

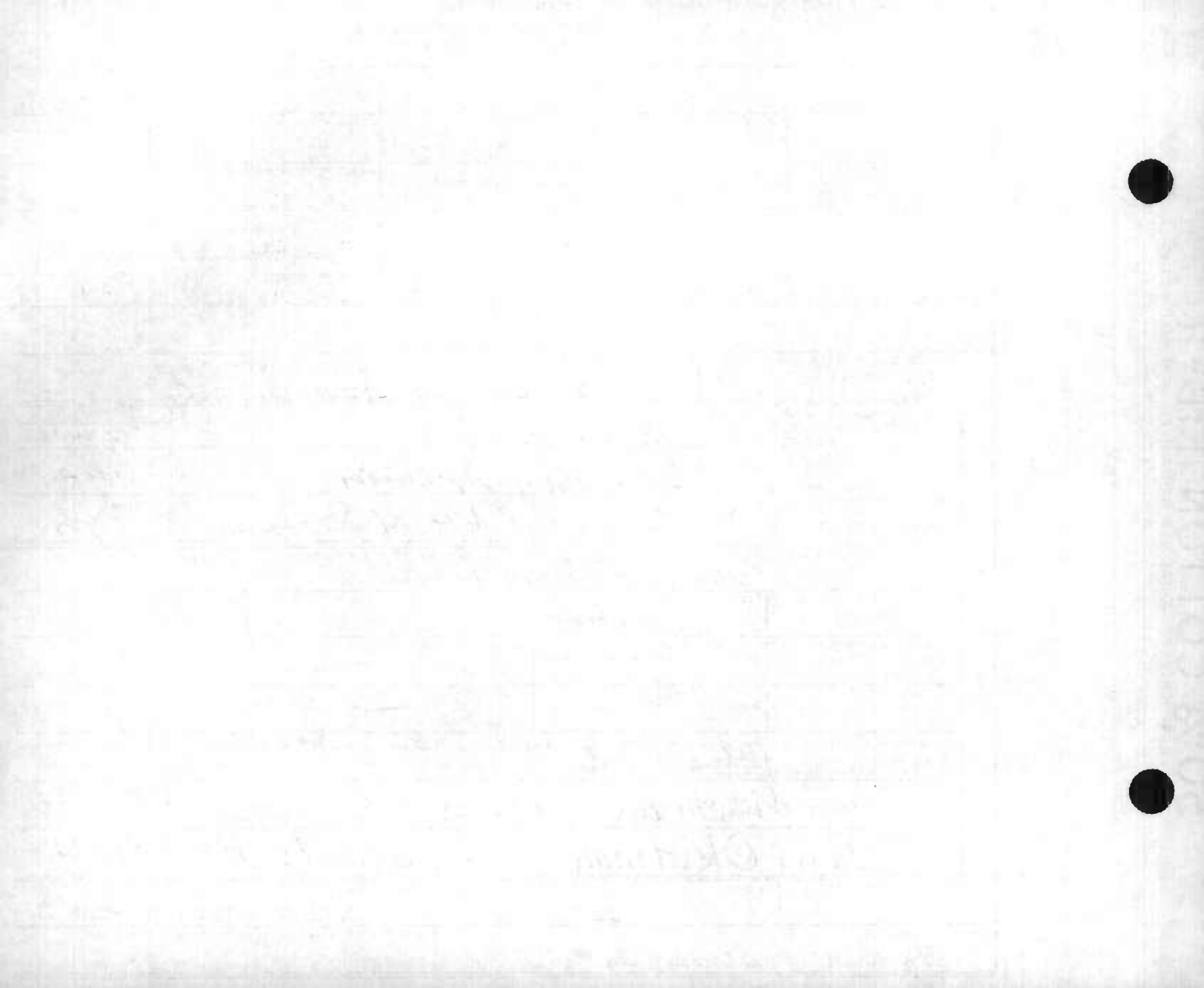
REG. NO.

23037

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Catherine A. Schwinger			8 -12 -86			6:00pm		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female	White	09 - 22 - 12	73 YRS.			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania	U.S.A.	Carroll County MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville	2832 Lake View Avenue		Homemaker			Domestic		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Pennsylvania			Franklin			Waynesboro		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS		
John ECK			Charlotte Bowling			12346 Old Penman Road 99999		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		
NO			161 40 1862			2832 Lake View Avenue Lois Welsh Sykesville, MD 21784		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart fail line</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Secondary Anemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Terminal Ca of Rectum</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>One week</u> <u>1 year</u> <u>3 yrs.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Urinary infection</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
2.25.85			Ca of Rectum			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> 19 <u>86</u> , to <u>Aug 12</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>July 8</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) and (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
Sani Okutman			MD			8.12.86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
Sani Okutman			Sykesville, Md 21784					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
BURIAL						HARBOUGH CEMETERY		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
HAIGHT FUNERAL HOME SYKESVILLE, MD 21784			AUG 15 1986					

BP

DHMH 16-30M 2/80
(VRA 15, 4)



00-14625

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must furnish a report.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										23038			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
William		Fred		Seipp				8-4-86					0949am
1. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		June 20 1923		63		MONTHS		DAYS		HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Carroll Co.		U.S.A.				Carroll						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Westminster		Carroll Co. Gen. Hospital		Custodian		West Office Post							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		46 W. George Street				21157	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
William Edward Seipp		Martha Zentz											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
Yes		WWII Army		217-20-3327		Margie Pauline Seipp Westminster, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u>												1 hour	
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
(b) <u>Acute Myocardial infarction</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-4-86</u> to <u>8-4-86</u> , that (I) (we) last saw the deceased alive on <u>5-4-86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
<u>Christopher N. Nagan</u>						8/4							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
CHRISTOPHER N. NAGAN		700A Poole Rd Westminster, Md. 21157											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		8-7-86		Lakeview Memorial		Edwardsburg Carroll Md.							
24. FUNERAL DIRECTOR		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE									
Ed 7th		AUG 7 1986		John Davidson									
254 East Main Street Westminster, Md. 21157													

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified and signed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MABEL MIDDLE L. LAST Shafer			2a. DATE OF DEATH MONTH 08 DAY 11 YEAR 86			2b. HOUR 11 10 AM	
3. SEX female		4. RACE cau.		5. DATE OF BIRTH MONTH 01 DAY 15 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST HARRY MIDDLE SARVER LAST		15. MOTHER'S MAIDEN NAME FIRST MAGGIE MIDDLE GLESSNER LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Lewis Shafer, 203 Snowfall Way 21157 Westminster, Md.			
18. CAUSE OF DEATH: Enter only one cause per line for 18a, 18b, and 18c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIFFUSE HISTOCYTIC LYMPHOMA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>5/16</u> , 19 <u>86</u> , to <u>6/11</u> , 19 <u>86</u> , that (1) (he) lost saw the deceased alive on <u>7/24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Howard G. Lanham</u> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/11/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD G. LANHAM, MD				22e. ADDRESS 215 WASHINGTON ST WESTMINSTER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-14-86		23c. NAME OF CEMETERY OR CREMATORY BERLIN		23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN SOMERSET PA	
24. FUNERAL DIRECTOR NAME <u>Robert Kyle Potts Jr.</u> ADDRESS <u>WESTMINSTER, MD.</u>				25a. DATE REC'D. BY REGISTRAR AUG 18 1986		25b. REGISTRAR'S SIGNATURE <u>Julia Anderson-Rucker</u>	

BP



00-17100

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23040
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Thomas E. Shaffer			2a. DATE OF DEATH MONTH 8 DAY 30 YEAR 86			2b. HOUR 1:15 MIN. AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 2 DAY 6 YEAR 1895		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.					
10. CITY OR TOWN OF DEATH Manchester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3415 Lineboro Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Manchester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3415 Lineboro Road 21102			
14. FATHER'S NAME FIRST Thomas MIDDLE E. LAST Shaffer				15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE J. LAST Richards							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 217-03-7424		17. INFORMANT ADDRESS Mr. Chester A. Shaffer, Manchester, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) 											
DUE TO, OR AS A CONSEQUENCE OF (c) 											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-9-1983 to 8-30-1986 , that (I) (we) last saw the deceased alive on 8-13-1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Chitrachedu Naganna						DEGREE 			22c. DATE SIGNED 9/3/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chitrachedu Naganna						22e. ADDRESS 700-A Poole Rd., Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-2-86		23c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.						25a. DATE REC'D. BY REGISTRAR SEP 5 1986			25b. REGISTRAR'S SIGNATURE John Davidson-Henderson		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

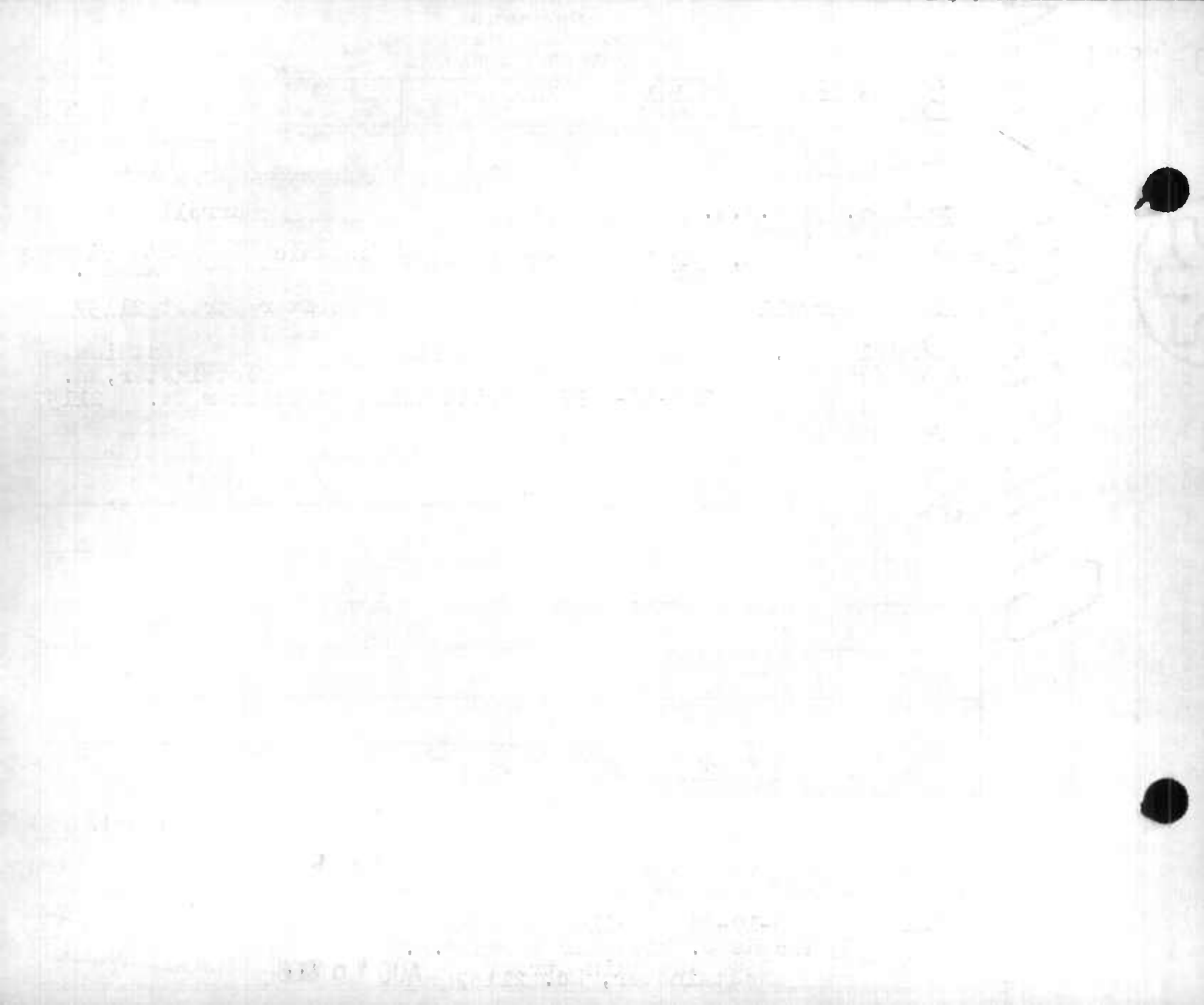
0-15618

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 3 0 4 1
 REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Robert Sharrer , Daniel Robert Sharrer		2a. DATE OF DEATH MONTH 8 DAY 16 YEAR 86		2b. HOUR 11:15 ^A _M	
3. SEX male		4. RACE cau.		5. DATE OF BIRTH MONTH 4 DAY 22 YEAR 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) West. Nursing & Convalescent Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY State Highway Admin.	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Daniel MIDDLE D. LAST Sharrer		15. MOTHER'S MAIDEN NAME FIRST Estella MIDDLE Mathias LAST Mathias		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 220-18-0497		17. INFORMANT ADDRESS Westminster, Md. Merritt Walsh 60 Webster St. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 8-5-86 , to 8-11-86 , that (I) (we) last saw the deceased alive on 8-16-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Vimala N. Nacanna		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/16/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIMALA N. NACANNA		22e. ADDRESS 700 A POOLE Rd, WESTMINSTER MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-19-86		23c. NAME OF CEMETERY OR CREMATORY Shiloh Cemetery		23d. LOCATION CITY OR TOWN Harpstead COUNTY Carroll STATE Md.	
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son		25a. DATE REC'D. BY REGISTRAR AUG 19 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson			

MEDICAL CERTIFICATION



30-81764

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 23042							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Artie Mae Smith					2a. DATE OF DEATH MONTH DAY YEAR 8 15 86			2b. HOUR 6 PM	
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 9-16-1894		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 91		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Golden Age Guest Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY					13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John Robert Killen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gillie May Moxley		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			17. SOCIAL SECURITY NO. 220-12-3320		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Cachexia and debility</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of mouth, old age.</u>		19. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Nagji J. Sureja</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/15/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nagji J. Sureja, M.D.		22e. ADDRESS 4212 Ridge Road, Westminster, MD 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/19/'86		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Montg. Md.			
24. FUNERAL DIRECTOR NAME Gartner Sandison F. H.		316 E. Diamond Ave., Gaithersburg, Md. 20877		25a. DATE REC'D. BY REGISTRAR AUG 20 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Sandison-Randall</i>			

100-100000-100
100-100000-100
100-100000-100



100-100000-100
100-100000-100
100-100000-100

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

23043

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Brian D. Tardio			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 8-1 1986			2b. HOUR M 11:24 P. M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 8, 1969	6. AGE (IN YEARS) (LAST BIRTHDAY) 17 YRS.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 0 0 0 0		2c. DATE PRONOUNCED DEAD 8-1 1986			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster				
14. FATHER'S NAME FIRST MIDDLE LAST Joseph L. Tardio			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gail DeLong			16. SOCIAL SECURITY NO. 214-64-1511			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			17. INFORMANT 1223 Nottingham Rd. Westminster, Md. 21157			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR:MIN MONTH DAY YEAR 10:45 PM 8-1 1986		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto/fixed object impact				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 32 & Bird View Road, Westminster, Carroll Co., Maryland				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 8-2-86			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/5/86		23c. NAME OF CEMETERY OR CREMATORY Conestoga Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Lancaster LINCASTER Pa.		
24. FUNERAL DIRECTOR <i>R. Harry Hightower</i>			ADDRESS Eckhardt Funeral Chapel Owings Mills, Md. 21117			25a. DATE REC'D. BY REGISTRAR AUG 4 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. THIS CERTIFICATE IS VALID FOR 10 DAYS. IF THE DEATH IS NOT FINAL, THE REGISTRAR WILL BE NOTIFIED. TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH THIS CERTIFICATE. PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MD. 21201

7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

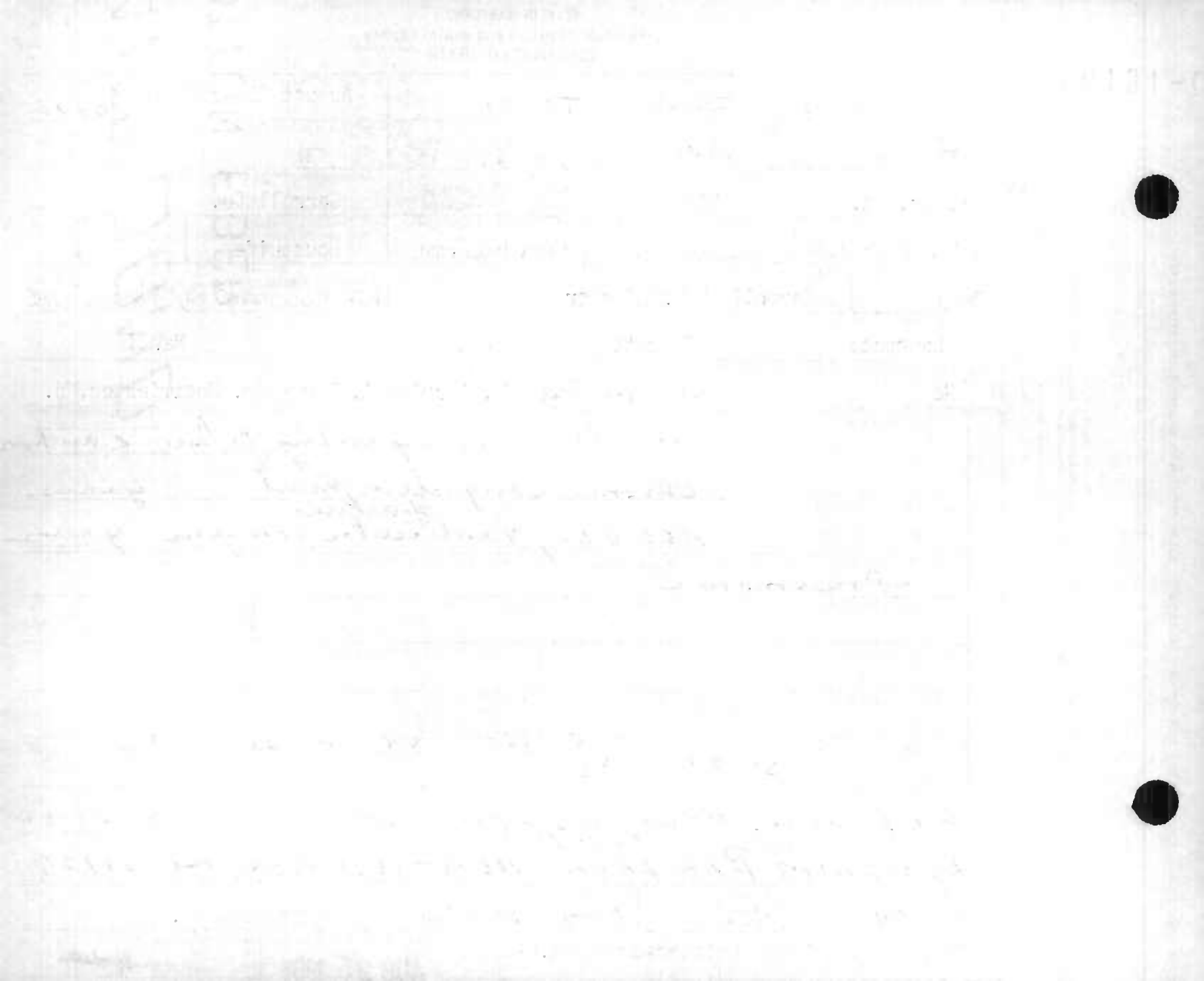
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

23044

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE JANE LAST TERRY			2a. DATE OF DEATH MONTH DAY YEAR August 23, 1986		2b. HOUR 0425M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 27 15		
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		10. CITIZEN OF WHAT COUNTRY? USA		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.		13. CITY OR TOWN OF DEATH Westminster		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GEN HOSPITAL		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE MD		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		17. STREET ADDRESS / ZIP CODE 150 BOWLING GREEN RD WESTMINSTER		
18. FATHER'S NAME FIRST Lawrence MIDDLE STREETT LAST		19. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE MARTIN LAST		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife.		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		22. SOCIAL SECURITY NO. 216-07-0058		23. INFORMANT Mr. Charles A. Terry Jr. Westminister, Md.		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute cardio respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) chronic congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD, ventricular aneurysm APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH less than 1 hour years years		25. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia		26. DATE OF OPERATION 1986		
27. DATE OF OPERATION 1986		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
33. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		35. LOCATION STREET CITY OR TOWN COUNTY STATE		
36. I certify that (I) (this hospital) attended the deceased from 8-18, 1986, to 8-23, 1986, that (I) (we) last saw the deceased alive on 8-23, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		37. SIGNATURE Ephraim Barzaga, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 8-23-86		
39. PHYSICIAN'S NAME (TYPE OR PRINT) EPHRAIM BARZAGA		40. ADDRESS NEW WINDSOR, Md. 21776		41. DATE REC'D. BY REGISTRAR AUG 25 1986		
42. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		43. DATE 8/26/86		44. NAME OF CEMETERY OR CREMATORY Carroll Cremation		
45. LOCATION CITY OR TOWN COUNTY STATE Hampstead, Md.		46. FUNERAL DIRECTOR Eline Funeral Home Reisterstown, Md. 21136		47. REGISTRAR'S SIGNATURE David R. Riddle		



00-15806

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MBP
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23045
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH DAY YEAR		2b. HOUR M	
1. DECEASED NAME (TYPE OR PRINT)		FIRST CHARLES		MIDDLE GARDNER		LAST UHLER	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 6 15 60	6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD	2d. HOUR M 2:02 PM
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) woods - 3209 Old Westminster Pike		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TREE TRIMMER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN FINKSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST CHARLES		MIDDLE D.		LAST UHLER		15. MOTHER'S MAIDEN NAME FIRST LAURA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-78-2468		17. INFORMANT ADDRESS Mrs. JACKIE UHLER		2808 CEDARHURST FINKSBURG 21048	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to abdomen (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 6-?- 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject found shot.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) woods		21f. LOCATION STREET 3209 Old Westminster Pike,		CITY OR TOWN Westminster	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <i>Charles P. Kokes</i>		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 8-19-86	
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D.		ADDRESS 111 Penn St. Balto., MD		21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 8-19-86		23c. NAME OF CEMETERY OR CREMATORY CARROLL CREMATION		23d. LOCATION CITY OR TOWN HAMPSTEAD CARROLL MD.	
24. FUNERAL DIRECTOR NAME ELINE FUNERAL HOME REISTERSTOWN, Md.		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 20 1986		25b. REGISTRAR'S SIGNATURE	

ELINE FUNERAL HOME REISTERSTOWN, D.

CREMATION 8-19-88 CARROLL CREMATION HAMPSTEAD CARROLL MD.

NO

217-28-2468 Mrs. JACKIE UHLER
CHARLES J. UHLER LAURA M. YASTADAY

MARYLAND BALTIMORE FINKSBURG

2808 CEDARHURST RD.

TREE TRIMMER

MARYLAND USA

ALL WHITE 6 15 80 25

GARDNER

00-16916

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH23046
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGUERITE T. VOLL			2a. DATE OF DEATH MONTH DAY YEAR 8 30 86			2b. HOUR 10:45A_M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 16 1905		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Westminister		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			
12b. KIND OF BUSINESS OR INDUSTRY Own Home									
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE 2046 Stillwater Rd. Sykesville Md. 21784									
14. FATHER'S NAME FIRST MIDDLE LAST Xavier Serr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosilia Swope						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-20-2820		17. INFORMANT Marguerite Ripper			ADDRESS Same as 13e.	
MEDICAL CERTIFICATION 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES MELLITUS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES	
								YEARS	
								YEARS	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 19 86 to JULY 23 19 86 that (I) we lost saw the deceased alive on JULY 23 19 86 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did not) view the body after death.								22b. SIGNATURE Arthur J. Lomant MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 9/2/86									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Arthur J. Lomant M.D.			22e. ADDRESS 1702 Liberty Rd. Eldersburg, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/3/86		23c. NAME OF CEMETERY OR CREMATORY Crestlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Maryland		
24. FUNERAL DIRECTOR 1630 Edmondson Ave. Catonsville, Md. 21228 Leroy M. & Russell C. Witzke Funeral Home					25a. DATE REC'D. BY REGISTRAR SEP 3 1986		25b. REGISTRAR'S SIGNATURE Lester Borden		

BP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-15643

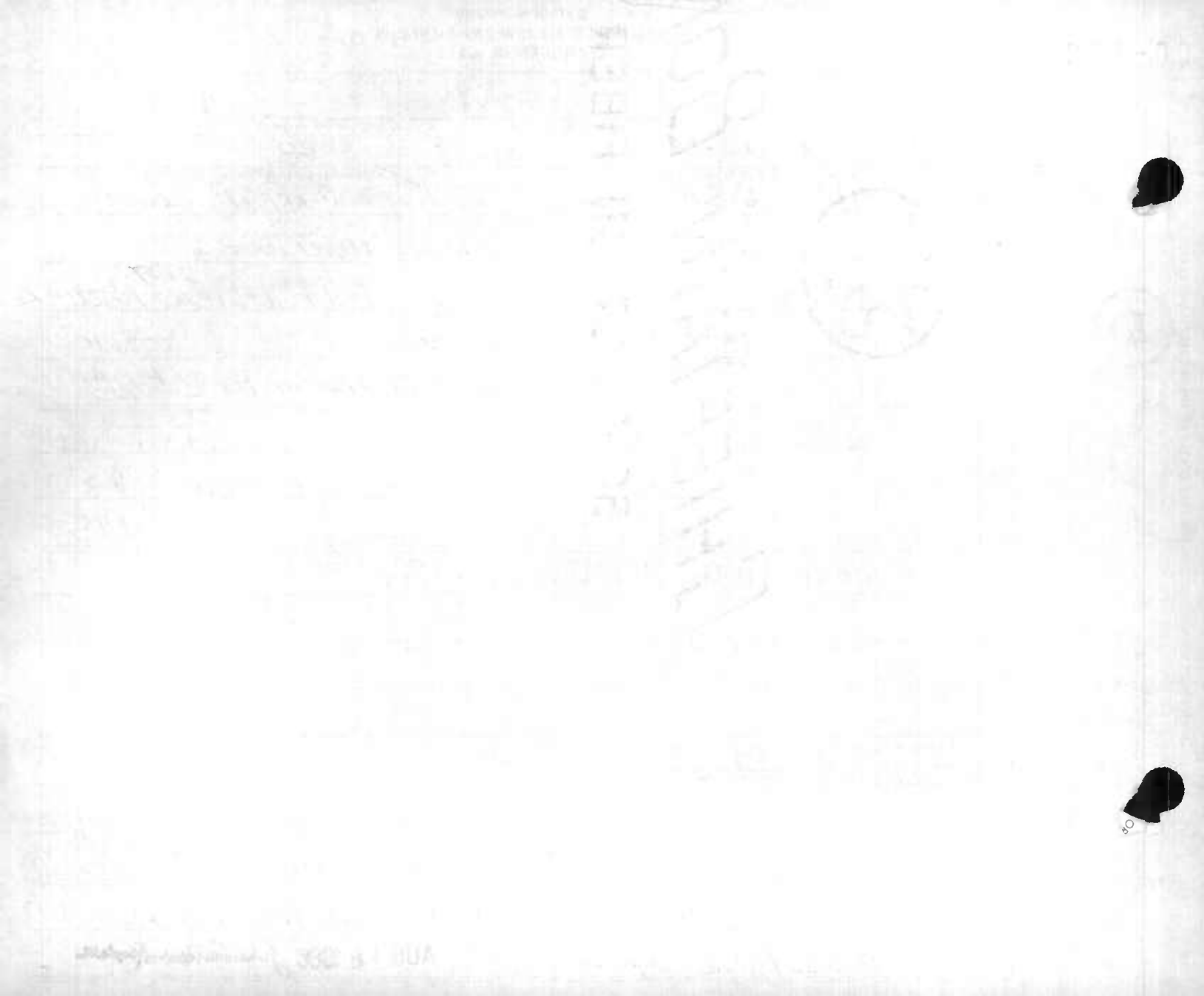
23047

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles R Weisengoff			MONTH DAY YEAR 8 16 86			10 ⁴⁹ AM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 01 - 01 - 18		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD					
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Never worked		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4101 Baltimore Nott Pike 21191		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Weisengoff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Kozlar								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-24-8256		17. INFORMANT ADDRESS Pleasant View Nursing Home Mt. Airy, MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic coronary disease</u> (c) <u>General atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>BRONCHITIS, Retardation, COPD</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>		
									<u>YRS</u>		
19a. DATE OF OPERATION									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I, this hospital) attended the deceased from <u>4/20/86</u> 19 <u>86</u> to <u>8/15</u> 19 <u>86</u> , that (I, we) lost <u>8/17</u> 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I, we) did (did not) view the body after death.											
22b. SIGNATURE <u>Melvin J Kordon MD</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/16/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MELVIN J KORDON MD</u>						22e. ADDRESS <u>2000 Century Plaza Columbia MD 21044</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>8-19-86</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Irrington Baltimore MD</u>				
24. FUNERAL DIRECTOR NAME ADDRESS <u>Haight Funeral Home Sykesville, MD</u>						25a. DATE REC'D. BY REGISTRAR <u>AUG 18 1986</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rodden</u>			

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, show any injury, or other traumatic event, the medical examiner whose certificate is attached to this certificate.



00-15524

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										23048 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FRANK ROBERTS ZAMBITO										2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 8 12 86 <input type="checkbox"/> 9 1 86	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 7 DAY 9 YEAR 1914	6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD MONTH 8 DAY 12 YEAR 86		2b. HOUR AM 9 PM 00			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHALKROLL MD.					
10. CITY OR TOWN OF DEATH ELDERSBURG		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 767 COVINGTON COURT				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES		12b. KIND OF BUSINESS OR INDUSTRY FOOD PRODUCER			
13a. USUAL RESIDENCE (IN HOME, IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE OF DECEASED) NEW YORK		13b. STATE NEW YORK		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 32 ARCADIA ST 99999					
14. FATHER'S NAME FIRST Charles MIDDLE LAST Zambito			15. MOTHER'S MAIDEN NAME FIRST Pauline MIDDLE LAST Monachino			17. INFORMANT ADDRESS Anthony Vozella Woburn, MASS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. ?								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULM. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Daniel I. Welliver			TITLE (SPECIFY) AST. DEP			MEDICAL EXAMINER 218 WASHINGTON HEIGHTS WASHINGTON, MD.			DATE SIGNED 8-12-86		
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER			ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-16-86			23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Woburn Middlesex Mass.		
24. FUNERAL DIRECTOR NAME HAIGHT FUNERAL HOME ADDRESS SYKESVILLE, MD			25a. DATE REC'D BY REGISTRAR AUG 15 1986			25b. REGISTRAR'S SIGNATURE [Signature]					

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